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ABSTRACT

Hearings were held concerning community-based mental health services for children. In an opening statement, Chairwoman Schroeder discussed issues of children's mental health and suggested that the committee study: (1) the effectiveness of community-based care in a model service system in California; (2) the importance of having service systems in place prior to a crisis; (3) creative funding strategies; and (4) the impact of inappropriate services on families. A fact sheet discusses the prevalence of childhood mental health problems; youth homelessness; lack of mental health care for children; inappropriate institutionalization; inadequate research in childhood mental health; inadequate insurance; and limited federal support. Statements from other committee members were included in the record. Seven other individuals presented statements. These statements included descriptions of the attempts of the State of Virginia to restructure its services and funding to better meet the needs of troubled youths and families; a demonstration community-based services project at Fort Bragg, North Carolina; and the California model system of care, a system expanded from the earlier Ventura model. (BC)

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CLOSE TO HOME: "COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN"

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ED338441

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 29, 1991

Printed for the use of the
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CLOSE TO HOME: COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN

MONDAY, APRIL 29, 1991

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The select committee met, pursuant to call, at 10 a.m., in Room 2322, Rayburn House Office Building, Hon. Patricia Schroeder, (chairwoman of the select committee) presiding.

Members Present: Representatives Schroeder, Wolf, Weldon, Miller, Barrett and Smith.

Staff Present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; Julie Shroyer, professional staff; May Kennedy, professional staff; Danielle Madison, minority staff director; Carol Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairwoman **Schroeder**. Good morning, Governor.

Governor **Wilder**. Good morning, Madam Chairman.

Chairwoman **Schroeder**. Glad to see you.

Governor **Wilder**. I apologize for the delay.

Chairwoman **Schroeder**. We thought maybe you had gone by the Transportation Subcommittee to get a little more funding for highways, but now that you made it this morning through our wonderful traffic, let me go ahead and call this to order and say how pleased we are that you made it and got to share the great joys of commuting from Northern Virginia to Washington.

First of all, we are very, very pleased to have this hearing because we think all of us in America have ignored children's mental health needs much too long. We know there are at least ten million children who have mental health problems. Every day we are learning more about the repercussions.

Number one, suicides are on the increase, and we are seeing more and more about the effects of divorce on children, and the startling statistic is that only one out of five children that have mental health problems are getting any care at all.

We are also finding that about half of those who are getting care are being institutionalized needlessly, and that the whole family can be affected.

Marriages and finances obviously can be affected and fall apart. Sibling needs can often be neglected. Families feel very isolated. All sorts of things can happen.

It is not going to be all that gloom and doom on this gloomy morning because at least we have some model programs that have shown that community and family-based programs save money and also get better results.

California, it has been shown, could save $171 million in two years on group home care costs alone, and Virginia found that they spent over $100,000 a year on institutional care for a single child if we had community-based programs.

Direct service costs in our institution-based system are now more than $3 billion a year. But the federal response has been very piecemeal. Medicaid coverage is very spotty and difficult to get. We set aside ten percent of the ADAMHA block grant for children, but do not require states to report on how they expended that money. We also tend to ignore the private insurance companies' policy of reimbursing only for institutional care, that seems to then drive the preference for institutional care.

I welcome our witnesses this morning. We have got a very distinguished group. We want you to know that this committee is listening. We are trying. We want to try and do what we can to act.

[Opening statement of Hon. Patricia Schroeder follows:]

OPENING STATEMENT OF HON. PAT SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO AND CHAIRWOMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Today, the Select Committee will examine ways to meet the unique needs of children with serious mental disturbances. Some of these children do require hospitalization, but many do not, and for far too many years we have failed to provide troubled children and their families with the services they need.

Commissions, professionals and parents have called for these services for more than twenty-five years, public and foundation funders have begun to establish model systems of care, and organizing groundwork has been laid at the state level in every state.

We must now turn rhetoric into reality. This discussion comes not a moment too soon because the need is great. More than 10 million children suffer from some sort of mental health problem. According to the recently released Office of Technology Assessment Adolescent Health Report, 1 out of 5 adolescents has a diagnosable mental disorder. In my own state of Colorado, an estimated 40,000 children and adolescents suffer from serious emotional disturbances.

Some policy makers and members of the general public tend to minimize the significance of childhood disorders. They shrug off the emotional pain of children, assuming that "they'll grow out of it." They are sadly mistaken: the adverse affects of many untreated disorders in children persist into adulthood.

Meanwhile, the majority of troubled children—as many as 80%—receive either inappropriate care or none at all.

The number of children and adolescents admitted to institutions has increased dramatically in the last 15 years, and an estimated 40% of children in costly institutional care are there inappropriately. Many states continue to allocate more than two-thirds of their children's mental health budget to residential or hospital treatment.

A recent study found that 5,000 children are placed outside of their own state each year in residential treatment facilities. Community-based services could bring many of them home, and could also address clear mental health needs of children in juvenile detention, foster care and other child-serving systems.

As my predecessor, George Miller, often pointed out where a child is treated often boils down to who will foot the bill rather than what type of treatment is best for the child. We can no longer afford such shortsightedness.

Mental disorders lead to a tremendous amount of suffering for afflicted children and youth and their families, and they impose a costly burden on society. Direct service costs have risen to more than $3 billion a year.

Beyond the financial costs to our society is the staggering emotional cost of children's mental disorders on every member of an afflicted child's family. Parents without supportive services can become overwhelmed by the demands of caring for a mentally ill child at home. Others must give up custody of their children so that they become eligible for long-term institutional care. Siblings find their own needs unmet as parents focus on dealing with the child who is ill.

The Federal response in this critical area has been so piecemeal that we do not even have the national data necessary to monitor trends and set policy priorities. The Federal government manages to keep accurate counts of the numbers of chickens that are transported across state lines each year, yet the Federal agencies responsible for children's programs can only estimate how many young people are residing in various types of mental health care facilities throughout the country.

We can no longer live with what this says about the moral priorities of this country. It is time to listen and to act.

Today we will learn about (1) the effectiveness and cost-savings of community-based care in a model service system in California, (2) the importance of having mental health services in place prior to crises such as military deployments, (3) creative strategies for funding these systems of care and (4) the impact of lack of appropriate services on families.

I welcome all of our witnesses. Mental illness does not respect partisan boundaries, and this is an issue area in which there should be substantial common ground.

I am especially pleased that Governor Wilder could join us this morning to discuss the Virginia Commonwealth's community mental health initiative and its commitment to strengthening youth and families. I know that Virginia is doing some very interesting planning in the area of preventive services as well, and look forward to further examination of that key aspect of children's mental health at a later time.

CLOSE TO HOME: COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN

A FACT SHEET

MILLIONS OF CHILDREN SUFFER FROM MENTAL HEALTH PROBLEMS

- At least 7.5 million children (12% of those under 18) have diagnosable psychological disorders. Nearly half of them are severely disabled by their mental health problems. (U.S. Department of Health and Human Services [DHHS], 1990)

- Conduct disorders (characterized by symptoms such as verbal and physical aggression, anti-social behavior, and poor impulse control that are often associated with delinquent behavior) affect up to 5.5% of the child population. (Friedman, 1990)

- The suicide rate for young people ages 15 to 24 has nearly tripled during the past 30 years. Suicide is now the third leading cause of death for this age group. (Office of Technology Assessment [OTA], 1991; National Center for Health Statistics, 1991)

MENTAL HEALTH PROBLEMS CONTRIBUTE TO RUNNING AWAY AND HOMELESSNESS AMONG YOUTH

- Four out of five runaway youth suffer from depression, in contrast to 24% of non-runaway youth. Eighteen percent of runaway youth have attempted suicide, and an equal number have other serious mental health problems. (Yates, et al., 1988)

- Forty percent of runaway and homeless youth said that emotional conflict at home was a factor in their decision to leave home. (U.S. Government Accounting Office, 1989)

CHILDREN'S MENTAL HEALTH NEEDS ARE LARGELY UNMET BY EXISTING CHILD-SERVING SYSTEMS

- Only about 1 in 5 children who need mental health treatment receives it. (DHHS, 1990)

- When states were ranked by consumer advocates according to the quality of services they provide for seriously emotionally disturbed children, only Vermont, Ohio, New York, North Carolina, Maine and Alaska received as high a rating as 3 points out of a possible 5. (Torrey, et al., 1990)

- Only 30% of school children with behavioral and emotional disorders are identified and receive services under the Education of the Handicapped Act. In 1988, there was a 16.5% shortage of special education teachers for children with emotional disturbances. (Knitzer, 1990; U.S. Department of Education, 1990)

- Youth in juvenile detention facilities suffer clinical depression at almost three times the rate of other adolescents, and suicide occurs more than twice as frequently among detained youth. Many facilities offer only emergency mental health services rather than ongoing treatment. (American Medical Association Council on Scientific Affairs, 1990)

- A recent study of all Medi-Cal eligible children in California found that those in foster care were five times more likely to be hospitalized for mental health problems than other eligible children. But early intervention and treatment are rare; one study of black children in foster care found that 41% of those ages 6 to 12 and 80% of those under age 5 have not had mental health evaluations. (Halfon, et al., 1990; National Black Child Development Institute, 1989)

THOUSANDS OF CHILDREN ARE PLACED IN RESTRICTIVE SETTINGS, OFTEN INAPPROPRIATELY

- An estimated 50% of youth in residential treatment receive care that is inappropriate for their situation. (DHHS, 1990)

- In a 1986 survey, 37 states reported that 4,000 children were placed in out-of-state mental health facilities at an estimated cost of $215 million. In addition, 22,472 children were treated in state hospitals, often in remote locations, despite the demonstrated effectiveness of community-based programs. (National Mental Health Association [NMHA], 1989)

- Residential treatment of children has risen dramatically over the past several decades. Admission rates of youth in private psychiatric hospitals increased by 1,327% between 1971 and 1985. By contrast, private admission rates for those over 18 increased by only 32%. (Lerman, 1990)

- Children and youth represent the largest proportion of those under care in private psychiatric hospitals (41%). However, patients under 18 constitute relatively low percentages of inpatients served in multi-service mental health organizations (16%), in state and county mental hospitals (6%), and in general hospitals (6%). (DHHS, 1990)

- There are few community-based programs for adolescents with mental health problems. Consequently, adolescents are hospitalized for less serious mental health problems (e.g., non-dependent drug use) and spend more days in the hospital than young adults. (Butts & Schwartz, in press)

TOO FEW PROFESSIONALS SPECIALIZE IN CHILDREN'S NEEDS

- There are shortages in every subfield of children's mental health research, and many childhood mental health disorders are not adequately understood. Child psychiatry represents an extreme example of the recruitment problem; fewer than 100 academic child psychiatrists devote 30% or more of their time to research. (DHHS, 1990)

- Of the $13.8 million the National Institute of Mental Health budgets for training grants, less than one fourth is awarded to programs specializing in services for children. (Magrab & Wohlford, 1990)

ACCESS TO SERVICES LIMITED BY INADEQUATE INSURANCE

- In 1986, only half of adolescents' outpatient visits to mental health settings were covered by commercial health insurance or Medicaid. (OTA, 1991)

- Private insurance often covers only inpatient mental health treatment. The lack of alternative service coverage is evidenced by the finding that length of stay in residential treatment was longer for youth with private insurance than for those who paid any other way. (Butts & Schwartz, in press)

FEDERAL SUPPORT FOR CHILDREN'S MENTAL HEALTH SERVICES LIMITED

- By law, 10% of each state's Alcohol, Drug and Mental Services block grant funds are to be set aside for mental health services for children, but reports of actual expenditures are not required. As a result, the proportion of funds spent as intended is unknown. (Office of Treatment Improvement, 1991)

- Medicaid funding for community-based mental health services for children is very uneven. Most states have used the Rehabilitation, Clinic or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) options to reimburse some services, and one state has negotiated a difficult-to-obtain waiver to reimburse this kind of care. (Fox, 1990)

April 29, 1991

Let me yield now to the Ranking Minority Member, Mr. Wolf.

Mr. WOLF. Thank you.

I want to thank you, Madam Chair, for having this hearing and also welcome the Governor for taking the time out of his schedule to come up.

I have an opening statement which I am not going to read in full, but I do want to read a very small portion of it, just to make this point clear.

In addition to these hearings, I think we also should study those families that exhibit family health in order to model their success. A landmark study by two professors of family studies, Nick Stenitt and John De Frain, conclude that there are six characteristics that seem to account for success, happiness and strength of strong families: appreciation of family members, spending time together, good communication patterns, commitment to the family, a high degree of religious orientation, and the ability to deal with crisis in a positive manner.

To the extent that we work within this family strengths paradigm, we acknowledge that children can benefit from a close-to-home approach. Mental health professionals can only do so much. Where will the support for families spending time together come from? Where will the support of religious institutions enter into the mental health framework?

Creative use of community resources would allow corporate, secular and sectarian interests to work side by side in seeking policies with a common goal of family and community health. While I think this hearing is very, very good, I think the committee should also look at strong families and see what these families are doing right.

And again, I want to thank the Chair and thank you, Governor, for coming.

[Opening statement of Hon. Frank R. Wolf, follows:]

OPENING STATEMENT OF HON. FRANK R. WOLF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING REPUBLICAN MEMBER OF THE SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

We often speak of children as a "national treasure," or "our nation's future." Yet there is a dichotomy between our national rhetoric and our personal action. Although the data is largely very sketchy and we should proceed cautiously in interpreting exactly what it means, it seems more children today are exhibiting more severe mental and behavioral disorders. Where have these children come from? The vast majority of children determined to be suffering mental health problems are teenagers. If the numbers of disturbed children are increasing, why are they doing so at a time when the teenagers are a smaller percentage of our total population?

By the time children and adolescents have reached the point where they need mental health services, they have often been failed by other structures and systems in society such as the justice system, various social services systems and their own families. Adolescence is a difficult time for children even under normal family conditions. For today's children, many of whom are suffering from the effects of divorce, drug or alcohol abuse, child abuse or sexual abuse, the problems of adolescence become nearly unsurmountable.

Preventive health professionals speak about a "downstream" approach versus an "upstream" approach in treating these problems: the "downstream" approach is to grab these kids out of the raging waters and try to help them, while the "upstream" approach seeks to find out who is "upstream" throwing these kids in the water in the first place. Obviously we want to help the children who are already "downstream" and today we will be addressing how we can more appropriately serve these children. It seems that a setting which incorporates all of the community support services available and keeps these children as close to home and family as possible, should be most beneficial. But we should also look to an "upstream" approach and how we can prevent these children from having their childhoods drowned in a cultural sea change in which they often get caught in the undertow.

While there are significant number of childrens suffering from mental illness related to organic causes, the vast majority of those deemed in need of mental health services include children from broken homes, children from alcoholic families, or children who have been sexually or physically abused. Some observers and analysts identify a subgroup of neglected "unattached children" who have never formed a satisfactory relationship with a primary caregiver. For children who have grown up, never having learned to trust or love any one person, abnormal mental health is more the norm than the exception.

Obviously, strengthening families is a complex matter, and will require work on many fronts. There are far too many cultural and financial pressures on today's families. Families are operating under twin deficits of time and money. This is why we must reach out to the entire community, not just the paid professionals, in dealing with the mental health of our next generation. A number of those testifying here today have been involved on a personal level with this issue because of their personal experience with the mental health problems of children. No doubt, we can learn much from them about how the system makes it difficult to cope with these problems and how community resources could better aid them. In addition, less government red tape and more flexibility in developing programs and recruiting providers would greatly help. Since it is clear that institutional care is a costly and overused option and children deserve a more familial setting for treatment, our programmatic approaches must allow for innovative solutions that adapt to the changing needs of the community, yet put children first.

We should also study those families that exhibit family health in order to model their success. A landmark study by two professors of family studies, Nick Stinnett and John DeFrain concluded that six characteristics seemed to account for the success, happiness, and strength of strong families:

1. Appreciation of family members.
2. Spending time together.
3. Good communication patterns.
4. Commitment to the family.
5. High degree of religious orientation.
6. Ability to deal with crises in a positive manner.

Therefore, to the extent that we work within this paradigm of success, children can be benefitted by a closer to home approach. But mental health professionals can only do so much. Where will the support for families "spending time together" come from, Where will the support of religious institutions enter into the mental health framework? Creative use of community resources would allow corporate, secular and sectarian interests to work side by side in seeking policies with a common goal of family and community health. If our children are to be our nation's future, we must be committed to "upstream" approaches that avoid repeating the mistakes of our past.

Chairwoman **Schroeder**. Thank you.

And I am going to ask unanimous consent for everybody to put opening statements in the record so we can get right on with it since we are running a little late this morning.

Prepared Statement of Hon. Curt Weldon, a Representative in Congress From the State of Pennsylvania

Thank you, Chairwoman Schroeder, for holding this hearing today. We must focus our attention on strengthening community-based mental health facilities. Community and family oriented services will provide both a nurturing and a cost-effective atmosphere. It is also vital that we examine financial strategies that will provide innovative and highly effective services to children with mental health problems, with maximum family involvement.

I am pleased to introduce to the Members of the Select Committee, someone I have known and worked with for many years in Delaware County. Dr. Sandra S. Cornelius, welcome. Her educational background and years of experience working with children with mental health problems will enlighten us here today.

Until recently, Dr. Cornelius served 8 years as the administrator of Delaware County Government Department of Human Resources. Her extraordinary dedication to the handicapped community is exemplified by her persistence in seeking additional funding resources, community support, and other methods of expanding services under strict budget constraints. As administrator she was instrumental in the County being awarded a Robert Wood Johnson Foundation Grant. The grant will bring $1.48 million to Delaware County for youth services.

Dr. Cornelius has recently been named President of the Elwyn Institute. As you may know, Elwyn is the largest and oldest private facility for the disabled in the nation. Elwyn serves internationally as a role model in providing education and rehabilitative services.

Elwyn serves over 10,000 children and adults with mental and physical disabilities annually through its 40 locations located in California, Delaware, Israel, New Jersey, and Pennsylvania. Elwyn's large variety of programs adapts to individual needs and potential. Their programs strive for a family-like atmosphere focusing on personalized attention to health, development, and emotional fulfillment.

Community programs include: community living arrangements, supported living arrangements, community-based work, supported employment, vocational training, and job placement. Elwyn tailors its programs to people of all ages, ranging from infants to the elderly.

Her experience will be informative to us today as we chart the path of our children's future.

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

During my tenure as Chairman of the Select Committee on Children, Youth, and Families, we often took on the issues no one else wanted—the significant, yet unspoken concerns about our most vulnerable youth and their families. Perhaps the most disturbing issue that emerged was the dismal lack of attention paid to emotionally troubled children.

Despite years of silence about children with mental health problems, their presence is not unfamiliar. We know them as children who are too aggressive or too withdrawn, who have learning problems in school, or who will get into trouble with the law. Now we know that for many children, these are not just passing phases of childhood, but serious mental health problems.

A major achievement of the Select Committee, of which I am most proud, was bringing these issues out into the open. For too long, the stigma of emotional disturbance prevented many parents from seeking help.

But even when families seek guidance or needed services, there are few places to turn. The Select Committee, in its investigation of child welfare, juvenile justice and mental health systems, found that economic and social trends are fueling a collapse in children's services.

The state of children's mental health services, in particular, is a national disgrace. As many as 80% of the 7 to 9 million children with emotional disturbances get inappropriate mental health services or no services at all.

The long-awaited report on *Adolescent Health* released last week by the Congressional Office of Technology Assessment found that as many as one-fifth of adolescents experience diagnosable mental disorders, and that while many do not get any treatment at all, psychiatric hospitalization of teens has been escalating.

Most tragic is the scarcity of community-based, family-intervention services, which remain few and undersupported. In California, as many as 1 million children may have serious mental health problems, but as few as 6% receive mental health services in the State's public programs.

Despite the lack of services in California, I am especially pleased that we will have testimony today about a model community-based program in Ventura County that provides well-coordinated, multiagency services. Even for children at highest risk of out-of-home placement, this program has resulted in significant declines in state hospital use.

Such efforts, however, are few and far between. Across the nation, limited and overloaded mental health systems are serving only the most seriously ill youth. The alternatives for the rest are more costly and inappropriate institutionalization, foster care, or residential placements that only exacerbate the problem.

The federal response has been virtually no response at all. The current Alcohol, Drug and Mental Health Services Block Grant provides only token resources for seriously ill children. The National Institute of Mental Health has shifted its emphasis from direct services and improved state coordination to more and better research. Scientific inquiry is important, but without improved and expanded services, we won't keep troubled youth out of jail or adult psychiatric wards.

I have introduced a bill, "The Children's and Communities' Mental Health Systems Improvement Act" to establish a program of grants to states on a matching basis to provide community-based, comprehensive mental health services to children and youth with severe emotional distúrbances. My colleagues recognize the need to act. The bill has over 65 cosponsors—Republicans and Democrats alike.

I am delighted that this hearing will focus on the need for such services and that witnesses will provide new evidence that such services can and do work for children in communities across the country, and I want to thank all of you for your testimony.

OPENING STATEMENT OF HON. BILL BARRETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Thank you Madam Chairwoman.

I look forward to hearing from the witnesses, who have first hand knowledge of the problems that lead to children being admitted for pyscho-therapy, or other forms of treatment, at community-based mental health services.

This morning's hearing will bring to light one of the most pronounced and evident signs of the decline of America's families; the growing incidence of mental illness amongst America's children.

It is just appalling that there has been a 38 percent increase for children and adolescents admitted to inpatient care in psychiatric hospitals. That the number of teenagers admitted to for-profit psychiatric hospitals jumped 400 percent in the last 10 years.

What might have caused these increases? Could it be because of the decline in federal spending in the area of mental health as some would lead us to believe?

While there may be a slight degree of merit in that position, I believe the real crux of the matter is in the family; not the federal government. We all know of strong families who have had children with mental illness. However, most of the evidence that I've seen seems to point out that it is the disrupted and disadvantaged families where we are seeing the rise in mental disorders.

No wonder! With divorce rates in this country on the rise, coupled with the fact that a divorce can be the most tramatic period a child will ever have to face. As a matter of fact, Congress's own Office of Technology Assessment reported that children from divorced families were found to experience a variety of mental health problems five to six years after the divorce.

So that leaves us with the question: How can we at the federal level address this problem. Should we try to increase or target funding programs that assist children in overcomming, or at least recognizing, these problems?

While that may sound like the easier answer, it may not be entirely practical at this point, nor do I believe it addresses the problem in the long-run.

Indeed findings of the report in which the distinguished Governor of Virginia will describe to us this morning, that studied the Virginia mental health programs for children, emphasize better use and coordination of state dollars for child mental health treatment.

I'd like to include some information from the Nebraska Foster Care Review Board. Nebraska also identified many of the problems identified in the Virginia report and I think we came up with some innovative ways to address the needs of children in the Nebraska foster care system. I believe the committee will find this information helpful.

I'm sure the Governor wouldn't reject more federal dollars, I think he may agree that uncoordinated federal dollars with additional conditions set in Washington, DC, may not be what Virginia needs to receive. As a former Speaker of the Nebraska Legislature, I certainly wouldn't want to see that.

Thank you Madam Chairwoman, and I look forward to hearing the testimony from this morning's witnesses.

NEBRASKA'S FOSTER CARE REVIEW BOARD

The Nebraska Foster Care Review Act was passed by the Legislature in 1982, creating the Foster Care Review Board. The Act provides for citizen review of children in out-of-home care by Local Foster Care Review Boards. It also provides for a computerized tracking system of *all* children in out-of-home care. This is the only tracking system of its kind in the United States. Since 1982, approximately 25,000 children have been reported to the tracking system.

Currently we have 26 Local Boards, each consisting of at least 5 community volunteers who meet monthly to review cases of children who have been placed in out-of-home care and make recommendations regarding the child's permanent plan as required by Federal Law PL 96-272 and the Nebraska Foster Care Review Act. The recommendations are sent to the court that placed the child in care, the agency that has custody of the child, the child's attorney, and the county attorney.

The Nebraska Foster Care Review Board is participating in an Early Review Pilot Project, funded by the Edna McConnell Clark Foundation and adminisered by the National Association of Foster Care Reviewers. Four of our Local Boards in three sites are reviewing children as soon as possible following disposition. Three of the Boards are inviting participants to attend their meetings. Recommendations are being sent to all parties in the case from three of the four Early Review Boards.

These Boards have identified a number of barriers in services delivery for children who are removed from their families. I would be glad to provide that information for you if you are interested.

On any given day, there are approximately 3,800 children in out-of-home care and therefore eligible for review by the Foster Care Review Board. This includes children placed with the Department of Social Services, the Department of Corrections, the Department of Public Institutions, and private agencies. Because of budget limitations, the Review Board is only able to review approximately 1,400 of the children each year.

The Foster Care Review Board publishes an Annual Report each year containing data from the tracking system and from the Local Board reviews. The Annual Report also contains systemic recommendations. The 1990 Annual Report should be available within a few months. The following systemic problems were identified in the 1989 Report:

1. Children's cases are not pursued or never investigated; children are not interviewed.
2. There is a lack of knowledgeable and thorough investigations because some of the personnel who investigate these cases have not received training in child abuse and child sexual abuse and in how to investigate a child abuse or child sexual abuse cases.
3. Although some training has occurred, there are county attorneys, police officers, guardians ad litem, and judges who don't know how to deal with child abuse and child sexual abuse cases.
4. Some county attorneys are unwilling to file charges or prosecute child sexual abuse and child abuse cases.
5. There is a lack of counseling and rehabilitative services for victims and perpetrators. This is particularly true in the Western and rural portions of the State.
6. There is a lack of trained, specialized foster homes. This problem is acute in rural parts of the State.
7. There is a lack of timely planning for children in out-of-home care.

Citizen review provides fiscal savings over the long run. In its first year of reviewing children, Nebraska's Review Board looked at a 13-year old youth who had been placed in a state mental institution because his grandmother was unable to cope with his adolescent behaviors. What was to have been a 2-week evaluation lengthened into a 2-year stay, costing in excess of $116,000. The Review Board reviewed the case and noted the inappropriateness of the placement and the deterioration of the youth. As a result, the Review Board worked with the agency to have the youth moved to a more appropriate, less expensive group home placement.

In 1985, Dr. Ann Coyne from the University of Nebraska's School of Social Work conducted an independent evaluation of Nebraska's Foster Care Review Board. Dr. Coyne compared 1,174 children who had been reviewed by the Foster Care Review Board to a comparison group of 611 children who were similar in every way except they hadn't received a Review Board review. The study revealed that the reviewed children were over twice as likely to be placed for adoption as the non-reviewed children. The net per year savings to the state was $236,880. Since the average age of the adopted children was 12, Dr. Coyne reasoned that this savings would continue every year for 6-7 years until the children reached the age of majority.

Dr. Coyne repeated the evaluation in 1986. This time she found that reviewed children were 1.9 times more likely to be in adoptive placements and the fiscal savings to the state ws $277,200. This savings was in addition to the $236,880 continuing from the 1985 children who were no longer in the system. This made a total 2-year savings of $514,080.

A final evaluation was done in 1988. In this study, reviewed children were 4.7 times more likely to have adoption as their plan and 3.5 times more likely to be in adoptive placements than non-reviewed children. A savings of $249,480 was estimated which again should be added to the continuing savings from previous years. Dr. Coyne concluded that the major contribution of Review Board reviews was the extra "push" they give to the agency and court to take the necessary steps to obtain a permanent home for children.

Opening Statement of Hon. Ronald K. Machtley, a Representative in Congress From the State of Rhode Island

Thank you Madam Chairwoman and to my friend Mr. Wolf for holding this hearing on the all too long-ignored topic of bringing children's mental health services close to home. I am sure all of us can agree that there is no greater investment than in the well-being of our children, whether that be in improving their education or their health care. But despite our investments, there are increasing numbers of our children and teenagers with little peace of mind and happiness. We, as a nation, must look more closely at the needs of these children with serious emotional disturbances, because apparently our investments here are not paying off.

Our first look needs to be at the families of these children. The emotional pain many children suffer as a result of divorce, living with an alcohol or drug abusing parent, or being physically abused is devastating. With the growing rate of divorce and incidence of drug and alcohol addictions, family units continue to weaken and children's needs are ignored.

Promoting "family health" is where we need to begin. So often, children who spend time with their families, are appreciated by both parents, and are taught to approach life positively exhibit a good feeling of self-worth. Strong self-worth in a child is so closely tied to a strong family unit that children of weak, disrupted families are bound to not feel strongly about themselves. When one in five children has a developmental problem which can be directly traced to the dissolution of the family unit, we know where the root of children's mental problems lie.

Despite our ability to identify many parental problems as harmful to children, we do not address the problems of children in their homes. Our child welfare, juvenile justice, and mental health systems continue a pattern of taking children out of the home, treating the children in an isolated, institutional environment, and then placing them back into the home where the fundamental problems which disturbed the child still exist. As we all know, institutionalizing and treating troubled children is very expensive and is particularly costly when children relapse after being returned to their troubled home without support of the system. If a child cannot feel loved in their own home, than this greater problem will never be solved by institutionalizing the child away from the home.

We need to stop failing our children at such high cost and work on treating mentally-disturbed children in their homes and in the community. By providing community-based mental health services for those children, their needs can be addressed and the family can be examined to see what underlying problems may exist. By coordinating our already diverse children services into strong community-based programs, there will be greater access to mental health services for children while allowing them to remain close to home. This coordination will also stop the duplication of services on children and save our local and state governments money. This savings would increase the flexibility of where our children's welfare dollars are spent without having to directly invest more funds into one program or another. If our funds are invested in community-based mental health services for our children, we will be making the necessary investment to treat the needs of our children and families first.

Investment in our children's needs is something we do to protect their future. However, our actions of the past and present have been unable to stop the growing numbers of our children in need of mental health care. By changing the pattern and means by which we address depression and anxiety in our children, by looking into the health of these children at home, and by promoting family health, this investment in our children is certain to prosper.

Governor Wilder, we appreciate your being here. We appreciate all that you have done, and we look forward to your testimony of how Virginia has taken hold of this problem and tried to change it, and we appreciate that you care enough about the mental health of children to have given it this kind of attention.

Let me say we will put your statement in the record, and the floor is yours.

STATEMENT OF THE HONORABLE L. DOUGLAS WILDER, GOVERNOR, COMMONWEALTH OF VIRGINIA, ACCOMPANIED BY CHARLES KEHOE, DIRECTOR, VIRGINIA DEPARTMENT OF YOUTH AND FAMILY SERVICES, RICHMOND, VA

Governor **Wilder**. Thank you. Thank you very much, Madam Chairman and members of the committee.

Let me, first of all, commend you for the foresight and the vision to know the need for a committee such as this because I do not know of anything any more important in our time than to really concentrate on youth and families.

And I am pleased to have this opportunity to share with you briefly how we in Virginia are attempting to restructure our services and funding to better meet the needs of our troubled youth and families, and especially during these tight fiscal times.

I could recount an array of statistics from national as well as Virginia data, but I believe it is more important to consider the impact of our policies on people, and I would like to take a few moments to share with you a story of a 15 year old boy, somewhat composite, we will call Tony.

His father abused him as a young child, and to protect him, the child welfare system placed him in several foster homes and group homes. His mother divorced his father four years ago and has been living with her boyfriend recently, and while the other children respond to the boyfriend's parenting, Tony has been rebellious and aggressive, and as a result, the mother has gone to the Juvenile Court several times requesting help.

And not too long ago, Tony pushed a school administrator and was charged with assault and battery. So he spent the next year in and out of several juvenile correctional programs and facilities before returning home.

Now that he is back at school, he is two grades behind, and he is not eligible for special education services. He was referred to the local mental health center for counseling, but they have a waiting list, and no one specializes in working with children.

Understandably, his mother feels that he needs structure and control, and so she suggests a group home, but cannot afford it, and the courts have a long waiting list.

The welfare agency says they cannot pay since they do not have custody, and he is not abused or neglected. The schools say they cannot educate him if his behavior is not under control.

So as you might expect, the family is at a total loss as to what to do. Now, his story, as I am sure all of you know, is repeated time and time again across this country in every locality. Obviously how we choose to respond to him and his family will play no small role in determining whether he ends up with an education, with a productive job, and with the ability to support a family in the future.

His experience demonstrates that these children often bounce from agency to agency, from foster to group home to institution, and from funding stream to funding stream. They are often defined by the system whose door they happen to enter: a welfare child if he is in the welfare door; a juvenile justice child if he happens to come through that system; a school system child; or a mental health child.

But the truth be known, these children are often the same child. In Virginia, for example, we found that of the 14,000 names of children across four agencies, they were, in fact, only 4,933 children.

The facts likewise show that today very few public or private services exist to meet the needs of these youth and families in most of our communities, especially in Virginia and across the country. What services are available generally are not coordinated, and through categorical programs and funds, a child is often removed from his or her home, and the problem is then considered fixed.

All too often the child is then returned without adequate support, and clearly, the emotional cost to children, such as the one I have described, and families is extremely high.

So we need to make effective use of limited resources because the financial costs to taxpayers of this often unproductive cycle are too high. In Virginia, during fiscal year 1989 alone, taxpayers spent over $100 million on group or institutional care for these 4,993, and $72.8 million on it on restrictive, out-of-community programs.

Such care can be extremely costly. It ranges from $10,000 per child, as the chairman has indicated, to $120,000 per child. For some children, inpatient care or secure placement is the most appropriate and effective way to protect them, to meet their complex needs, or to protect the public safety.

Increasingly, however, states are beginning to realize that family-based services are very effective in meeting the needs of many of these same youths in their home communities and at a much lower cost to the taxpayer.

Now, while it is true that government must share responsibility in caring for these vulnerable children, government at every level must also be fiscally responsible in searching for the effective care. Federal reimbursements to states for foster care services, and I am referring to Title IV(e), an entitlement program for out-of-home care have grown dramatically in recent years from the $309 million in 1981 to now $1.8 billion in 1991.

In stark contrast, federal child welfare funds, and I am referring to Title IV-B, intended to prevent these placements rose only ten percent in constant dollars between 1980 and 1989, and totaled only $273 million in 1991.

In short, the federal government is putting its eggs in the wrong basket. What we have tried to do in Virginia in what we call an initiative is to concentrate on youth and family.

One of the first things that I did when I was sworn in—as a matter of fact, I think it was the first executive order that I signed—was to call the decade of the '90s the decade of youth and families. We have sought permanent solutions and common sense investments for the future in these regards.

Now, we have launched a thorough reconceptualization of the relationship between government and services for our troubled youth in an ongoing effort being overseen by a new Council on Community Services for Youth and Families. It is a cross-secretarial, interagency council.

For long-term success to be realized, we know that local communities must be active participants in this process. The role of federal and state government is to remove the barriers, to provide flexibility, and to require accountability.

We must direct decisions, authority and responsibility to communities who know best the needs of their youth and families. Simply put, it is imperative that we get back to the basic values of individual family and community responsibility, and toward achieving these ends, my administration is committed to:

One, responding to the needs of youth and families with the ultimate goal of preserving and strengthening the family unit.

Two, emphasizing prevention and providing early intervention for families before serious damage is done.

And, three, preventing out-of-home placement when possible, and when such care is necessary, reuniting children with families as soon as possible.

To date as we've sought to forge new philosophies and procedures for the well-being of youth and families throughout the state, our efforts have brought together leaders from the public, private and family sectors. We have involved experts from the juvenile justice system, education, child welfare, health, mental health, and substance abuse systems.

We likewise have gone to great lengths to involve judges, local government officials, parents, advocates and providers as active partners in this effort to bring comprehensive change to the systems which currently serve our youth and families.

Turning to the specific goals of the council, we are currently working to increase interagency collaboration in service delivery and management; to coordinate the funding of the services across these agencies; to contain the cost of expensive residential care; and to expand community-based, early intervention and prevention services.

As you might expect, this interagency effort remains a high priority for us, and the council's budget for the 1990–92 biennium survived three series of budget reductions to address more than $2 billion revenue shortfalls in our state general funds. We did not touch it at all.

The council has increased this appropriation substantially by redirecting and pooling existing funds that pay for residential care across the four child serving agencies.

Obviously, this demonstrates the significant commitment on behalf of agencies to share funds, even when they are experiencing major budget reductions.

In addition to these efforts, I am pleased to say that through a grant program, we awarded almost $3.4 million in seed money to five communities across our state to transition our system to one of community services.

The work of the council will culminate in an interagency budget and legislative package which will be considered by our next session of the general assembly beginning in 1992. Now, while this package shall include comprehensive changes, I will limit my comments today to a few of the ideas we are exploring towards restructuring our funding.

Looking at specifics, we intend to combine several of the 16 funds across four agencies that pay for residential care into one state pool of funds. We want to create a trust fund through new monies and private foundation funds, to develop community services and to transition our system.

We want to redirect funds which are supporting state institutions to the state pool of funds after youth are effectively transitioned to community programs, and the state programs can be down-sized.

We will allocate state funds to localities through one fund based on youth population and the ability to pay factors, and also access the local funds pools to pay for services which will be based on the needs of individual families as determined by the local team.

Now, usually when we come, we ask for things and we suggest things and we have no solutions. I am not suggesting that we have a solution today, but I do think we have some suggestions, and as I have said, I applaud those members of Congress who are willing to rethink how the federal government addresses the needs of seriously troubled youth because the commitment of such farsighted representatives to overhaul the child welfare system and to focus on the mental health needs of youth is very encouraging.

From our perspective, I would request the select committee to consider the following actions:

One, to redirect existing federal dollars to provide preventive and early intervention services;

Two, to remove the present restrictions on foster care IV(e) funding to pay for services that prevent out-of-home placements; and

Three, to ensure federal funding at whatever level and to make certain that it is stable;

Four, and when focusing on specific mental health or child welfare legislation, I would ask that you keep in mind that these systems are often dealing with the very same individual child. Most of the severely emotionally disturbed youngsters are already identified. They are in foster care, in special education classes, and in the juvenile justice system. So, therefore, future funding needs to provide incentives and flexibility to develop community services across the systems to serve the troubled youth and their families.

I would urge you to consider coordinating the programmatic and the funding requirements for these two initiatives.

Now, there is strong consensus that the country must invest in its physical infrastructure: roads, airports and public facilities. And I think, likewise, that we must make the very hard policy choices and invest in our human infrastructure, and that is our youth and our families.

Madam Chair, as I have said, your select committee has already had the vision. Now you have further opportunity to provide the leadership and the direction, and I certainly do look forward to working with you to create a better system of care for our seriously at risk and troubled children in the '90s because I think when we invest in our youth and families today, we will not be paying the continuing escalating costs of tomorrow, those who will be in our prisons, those who will be on our welfare rolls, and those who will be lying on some slab in a morgue.

I think we can prevent much of that, and to that end I pledge my cooperation, and I am very pleased to have the occasion to be with you this morning.

Thank you.

[Prepared statement of Governor L. Douglas Wilder follows:]

PREPARED STATEMENT OF L. DOUGLAS WILDER, GOVERNOR, COMMONWEALTH OF VIRGINIA, RICHMOND, VA

COORDINATING SERVICES AND FUNDING
FOR
TROUBLED YOUTH AND FAMILIES
COMMONWEALTH OF VIRGINIA

GOOD MORNING, MADAM CHAIR AND MEMBERS OF THE SELECT COMMITTEE.

I AM PLEASED TO HAVE THIS OPPORTUNITY TO SHARE WITH YOU HOW WE IN VIRGINIA ARE RESTRUCTURING OUR SERVICES AND FUNDING TO BETTER MEET THE NEEDS OF OUR TROUBLED YOUTH AND FAMILIES DURING THESE TIGHT FISCAL TIMES.

EXPERIENCES OF TROUBLED YOUTH AND FAMILIES

I COULD RECOUNT AN ARRAY OF STATISTICS FROM NATIONAL AND VIRGINIA DATA, BUT I BELIEVE IT MORE IMPORTANT TO CONSIDER THE IMPACT OF OUR POLICIES ON PEOPLE.

I WOULD LIKE TO TAKE A FEW MOMENTS TO SHARE WITH YOU A STORY OF A FIFTEEN YEAR OLD BOY, TONY.

TONY'S FATHER ABUSED HIM AS A YOUNG CHILD. TO PROTECT HIM, THE CHILD WELFARE SYSTEM PLACED HIM IN SEVERAL FOSTER HOMES AND GROUP HOMES.

TONY'S MOTHER DIVORCED HIS FATHER FOUR YEARS AGO AND HAS BEEN LIVING WITH HER BOYFRIEND RECENTLY. WHILE THE OTHER CHILDREN RESPOND TO THE BOYFRIEND'S PARENTING, TONY HAS BEEN REBELLIOUS AND AGGRESSIVE. AS A RESULT, THE MOTHER HAS GONE TO THE JUVENILE COURT SEVERAL TIMES REQUESTING HELP.

NOT TOO LONG AGO, TONY PUSHED A SCHOOL ADMINISTRATOR AND WAS CHARGED WITH ASSAULT AND BATTERY. HE SPENT THE NEXT YEAR IN AND OUT OF SEVERAL JUVENILE CORRECTIONAL PROGRAMS AND FACILITIES BEFORE RETURNING HOME.

TODAY, BACK AT SCHOOL, TONY IS TWO GRADE LEVELS BEHIND; AND IS NOT ELIGIBLE FOR SPECIAL EDUCATION SERVICES.

TONY WAS REFERRED TO THE LOCAL MENTAL HEALTH CENTER FOR COUNSELING, BUT THEY HAVE A WAITING LIST AND NO ONE SPECIALIZES IN WORKING WITH CHILDREN.

UNDERSTANDABLY, HIS MOTHER FEELS TONY NEEDS STRUCTURE AND CONTROL. SHE SUGGESTS A GROUP HOME, BUT CANNOT AFFORD IT.

THE COURTS HAVE A LONG WAITING LIST.

THE WELFARE AGENCY SAYS THEY CANNOT PAY SINCE THEY DO NOT HAVE CUSTODY AND TONY IS NOT ABUSED/NEGLECTED.

THE SCHOOL SAYS THEY CANNOT EDUCATE HIM IF HIS BEHAVIOR IS NOT UNDER CONTROL.

AS YOU MIGHT EXPECT, THE FAMILY IS AT A LOSS.

TONY'S STORY---AS I AM SURE YOU KNOW---IS REPEATED TIME AND AGAIN EACH YEAR ACROSS THE COUNTRY.

OBVIOUSLY, HOW WE CHOOSE TO RESPOND TO TONY AND HIS FAMILY WILL PLAY NO SMALL ROLE IN DETERMINING....WHETHER HE ENDS UP WITH AN EDUCATION; WITH A PRODUCTIVE JOB AND WITH THE ABILITY TO SUPPORT A FAMILY IN THE FUTURE.

AS TONY'S EXPERIENCE DEMONSTRATES, THESE CHILDREN OFTEN BOUNCE FROM AGENCY TO AGENCY; FROM FOSTER HOME TO GROUP HOME TO INSTITUTION; AND FROM "FUNDING STREAM" TO "FUNDING STREAM."

THEY ARE OFTEN DEFINED BY THE SYSTEM WHOSE DOOR THEY HAPPEN TO ENTER: A WELFARE CHILD, A JUVENILE JUSTICE CHILD, A SCHOOL SYSTEM CHILD OR A MENTAL HEALTH CHILD.

BUT, THE TRUTH BE KNOWN, THESE CHILDREN ARE OFTEN THE SAME CHILD.

IN VIRGINIA, FOR EXAMPLE, WE FOUND THAT 14,000 NAMES OF CHILDREN ACROSS FOUR AGENCIES WERE IN FACT 4,993 CHILDREN.

TODAY, VERY FEW PUBLIC OR PRIVATE SERVICES EXIST TO MEET THE NEEDS OF THESE YOUTH AND THEIR FAMILIES IN MOST COMMUNITIES IN VIRGINIA AND ACROSS THE COUNTRY. WHAT SERVICES ARE AVAILABLE, GENERALLY ARE NOT COORDINATED.

THROUGH CATEGORICAL PROGRAMS AND FUNDS, A CHILD IS OFTEN REMOVED FROM HIS OR HER HOME, AND THE PROBLEM IS "FIXED."

ALL TOO OFTEN, THE CHILD IS THEN RETURNED WITHOUT ADEQUATE SUPPORT. CLEARLY, THE EMOTIONAL COSTS TO CHILDREN, SUCH AS TONY, AND FAMILIES ARE EXTREMELY HIGH.

EFFECTIVE USE OF LIMITED RESOURCES?

THE FINANCIAL COSTS TO TAXPAYERS FOR THIS OFTEN UNPRODUCTIVE CYCLE ARE ALSO HIGH.

IN VIRGINIA DURING FISCAL YEAR 1989, TAXPAYERS SPENT OVER $100 MILLION ON GROUP OR INSTITUTIONAL CARE FOR 4,993 CHILDREN, $72.8 MILLION OF IT ON RESTRICTIVE OR OUT-OF-COMMUNITY PROGRAMS.

SUCH CARE CAN BE EXTREMELY COSTLY, RANGING FROM $10,000 TO $120,000 PER CHILD.

FOR SOME CHILDREN, INTENSIVE INPATIENT CARE OR SECURE PLACEMENT IS THE MOST APPROPRIATE AND EFFECTIVE WAY TO PROTECT THEM; TO MEET THEIR COMPLEX NEEDS OR TO PROTECT THE PUBLIC'S SAFETY.

INCREASINGLY, HOWEVER, STATES ARE BEGINNING TO REALIZE THAT FAMILY-BASED SERVICES ARE VERY EFFECTIVE IN MEETING THE NEEDS OF MANY OF THESE SAME YOUTHS IN THEIR HOME COMMUNITIES AND AT A LOWER COST TO THE TAXPAYER.

WHILE IT IS TRUE THAT GOVERNMENT MUST SHARE RESPONSIBILITY IN CARING FOR VULNERABLE CHILDREN, GOVERNMENT AT EVERY LEVEL MUST ALSO BE FISCALLY RESPONSIBLE IN SEARCHING FOR EFFECTIVE CARE.

FEDERAL REIMBURSEMENTS TO STATES FOR FOSTER CARE SERVICES (TITLE IV-E)---AN ENTITLEMENT PROGRAM FOR OUT-OF-HOME CARE---HAVE GROWN DRAMATICALLY IN RECENT YEARS: FROM $309 MILLION IN 1981 TO $1.8 BILLION IN 1991.

IN STARK CONTRAST, FEDERAL CHILD WELFARE FUNDS (TITLE IV-B) INTENDED TO PREVENT THESE PLACEMENTS ROSE ONLY 10 PERCENT IN CONSTANT DOLLARS BETWEEN 1980 AND 1989.... AND TOTALLED ONLY $273 MILLION IN 1991. IN SHORT, THE FEDERAL GOVERNMENT IS PUTTING ITS EGGS IN THE WRONG BASKET.

THE VIRGINIA INITIATIVE

AS SOME OF YOU MAY KNOW, ONE OF MY FIRST ACTS AS GOVERNOR WAS TO ISSUE AN EXECUTIVE ORDER DIRECTING MY CABINET SECRETARIES AND THEIR RESPECTIVE AGENCIES TO COOPERATE IN ADVOCATING PROGRAMS FOR YOUTH AND FAMILIES. FROM THE OUTSET, WE HAVE SOUGHT PERMANENT SOLUTIONS AND COMMON SENSE INVESTMENTS FOR THE FUTURE IN THESE REGARDS.

ACCORDINGLY, WE HAVE LAUNCHED A THOROUGH RECONCEPTUALIZATION OF THE RELATIONSHIP BETWEEN GOVERNMENT AND SERVICES FOR OUR TROUBLED YOUTH....AN ON-GOING EFFORT BEING OVERSEEN BY THE STATE'S NEW COUNCIL ON COMMUNITY SERVICES FOR YOUTH AND FAMILIES....A CROSS-SECRETARIAL INTERAGENCY COUNCIL.

OF COURSE, FOR LONG-TERM SUCCESS TO BE REALIZED, LOCAL COMMUNITIES MUST BE ACTIVE PARTICIPANTS IN THE PROCESS.

THE ROLE OF FEDERAL AND STATE GOVERNMENT IS TO REMOVE BARRIERS, TO PROVIDE FLEXIBILITY AND TO REQUIRE ACCOUNTABILITY. WE MUST DIRECT DECISIONS, AUTHORITY AND RESPONSIBILITY TO COMMUNITIES WHO KNOW BEST THE NEEDS OF THEIR YOUTH AND FAMILIES. SIMPLY PUT, IT IS IMPERATIVE THAT WE GET BACK TO THE BASIC VALUES OF INDIVIDUAL, FAMILY AND COMMUNITY RESPONSIBILITY.

TOWARD ACHIEVING THESE ENDS, MY ADMINISTRATION IS COMMITTED TO:

- RESPONDING TO THE NEEDS OF YOUTH AND FAMILIES WITH THE ULTIMATE GOAL OF PRESERVING AND STRENGTHENING THE FAMILY UNIT;
- EMPHASIZING PREVENTION AND PROVIDING EARLY INTERVENTION FOR FAMILIES BEFORE SERIOUS DAMAGE IS DONE; AND
- PREVENTING OUT-OF-HOME PLACEMENT WHEN POSSIBLE....AND WHEN SUCH CARE IS NECESSARY, REUNITING CHILDREN WITH FAMILIES AS SOON AS POSSIBLE.

TO DATE, AS WE HAVE SOUGHT TO FORGE NEW PHILOSOPHIES AND PROCEDURES FOR THE WELL-BEING OF YOUTH AND FAMILIES THROUGHOUT THE STATE, OUR EFFORTS HAVE BROUGHT TOGETHER LEADERS FROM THE PUBLIC, PRIVATE AND FAMILY SECTORS

WE HAVE INVOLVED EXPERTS FROM THE JUVENILE JUSTICE; EDUCATION; CHILD WELFARE; HEALTH; MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS.

WE LIKEWISE HAVE GONE TO GREAT LENGTHS TO INVOLVE JUDGES, LOCAL GOVERNMENT OFFICIALS, PARENTS, ADVOCATES AND PROVIDERS AS ACTIVE PARTNERS IN THIS EFFORT TO BRING COMPREHENSIVE CHANGE TO THE SYSTEMS CURRENTLY SERVING VIRGINIA'S YOUTH AND FAMILIES.

TURNING TO THE SPECIFIC GOALS OF THE COUNCIL, WE ARE CURRENTLY WORKING TO:

- INCREASE INTERAGENCY COLLABORATION IN SERVICE DELIVERY AND MANAGEMENT;
- COORDINATE FUNDING OF SERVICES ACROSS AGENCIES;
- CONTAIN COSTS OF EXPENSIVE RESIDENTIAL CARE; AND
- EXPAND COMMUNITY-BASED, EARLY INTERVENTION AND PREVENTIVE SERVICES.

AS YOU MIGHT EXPECT, THIS INTERAGENCY EFFORT REMAINS A HIGH PRIORITY FOR MY ADMINISTRATION. THE COUNCIL'S BUDGET FOR THE 1990-92 BIENNIUM SURVIVED THREE SERIES OF BUDGET REDUCTIONS TO ADDRESS MORE THAN $2 BILLION REVENUE SHORTFALL IN OUR STATE GENERAL FUNDS.

THE COUNCIL HAS INCREASED THIS APPROPRIATION SUBSTANTIALLY BY REDIRECTING AND POOLING EXISTING FUNDS THAT PAY FOR RESIDENTIAL CARE ACROSS THE FOUR CHILD SERVING AGENCIES.

OBVIOUSLY, THIS DEMONSTRATES THE SIGNIFICANT COMMITMENT ON BEHALF OF AGENCIES TO SHARE FUNDS....EVEN WHEN THEY ARE EXPERIENCING MAJOR BUDGET REDUCTIONS.

IN ADDITION TO THESE EFFORTS, I'M PLEASED TO SAY THAT---THROUGH A GRANT PROGRAM---WE AWARDED ALMOST $3.4 MILLION IN SEED MONEY TO FIVE COMMUNITIES ACROSS THE COMMONWEALTH TO TRANSITION OUR SYSTEM TO ONE OF COMMUNITY SERVICES.

THE WORK OF THE COUNCIL WILL CULMINATE IN AN INTERAGENCY BUDGET AND LEGISLATIVE PACKAGE TO BE CONSIDERED IN THE 1992 GENERAL ASSEMBLY SESSION.

WHILE THIS PACKAGE SHALL INCLUDE COMPREHENSIVE CHANGES, I WILL LIMIT MY COMMENTS TODAY TO A FEW OF THE IDEAS WE ARE EXPLORING TOWARD RESTRUCTURING OUR FUNDING.

LOOKING AT SPECIFICS, WE INTEND TO:

- COMBINE SEVERAL OF THE SIXTEEN FUNDS ACROSS FOUR AGENCIES THAT PAY FOR RESIDENTIAL CARE INTO ONE STATE POOL OF FUNDS.
- CREATE A TRUST FUND THROUGH NEW MONIES AND PRIVATE FOUNDATION FUNDS TO DEVELOP COMMUNITY SERVICES AND TRANSITION OUR SYSTEM.
- REDIRECT FUNDS SUPPORTING STATE INSTITUTIONS TO THE STATE POOL OF FUNDS AFTER YOUTH ARE EFFECTIVELY TRANSITIONED TO COMMUNITY PROGRAMS AND THE STATE PROGRAMS CAN BE DOWNSIZED.
- ALLOCATE STATE FUNDS TO LOCALITIES THROUGH ONE FUND BASED ON YOUTH POPULATION AND ABILITY TO PAY FACTORS; AND
- ACCESS THE LOCAL FUNDS POOLS TO PAY FOR SERVICES BASED ON THE NEEDS OF INDIVIDUAL FAMILIES AS DETERMINED BY THE LOCAL TEAM.

REQUESTED FEDERAL RESPONSE

I DO NOT BELIEVE ANYONE SHOULD TESTIFY BEFORE CONGRESS WITHOUT OFFERING CONSTRUCTIVE SUGGESTIONS. I APPLAUD THOSE MEMBERS OF CONGRESS WHO ARE WILLING TO RETHINK HOW THE FEDERAL GOVERNMENT ADDRESSES THE NEEDS OF SERIOUSLY TROUBLED YOUTH.

THE COMMITMENT OF SUCH FAR-SIGHTED REPRESENTATIVES TO OVERHAUL THE CHILD WELFARE SYSTEM AND FOCUS ON THE MENTAL HEALTH NEEDS OF YOUTH IS ENCOURAGING.

FROM VIRGINIA'S PERSPECTIVE, I REQUEST THE SELECT COMMITTEE TO CONSIDER THE FOLLOWING ACTIONS:

ONE, REDIRECT EXISTING FEDERAL DOLLARS TO PROVIDE PREVENTIVE AND EARLY INTERVENTION SERVICES;

TWO, REMOVE RESTRICTIONS ON FOSTER CARE IV-E FUNDING TO PAY FOR SERVICES THAT PREVENT OUT-OF-HOME PLACEMENTS;

THREE, ENSURE FEDERAL FUNDING---AT WHATEVER LEVEL---IS STABLE.

FOUR, WHEN FOCUSING ON SPECIFIC MENTAL HEALTH OR CHILD WELFARE LEGISLATION, I WOULD ASK THAT YOU KEEP IN MIND THAT THESE SYSTEMS ARE OFTEN DEALING WITH THE SAME CHILD. MOST OF THE SEVERELY EMOTIONALLY DISTURBED YOUNGSTERS ARE ALREADY IDENTIFIED.

THEY ARE IN FOSTER CARE, IN SPECIAL EDUCATION CLASSES AND IN THE JUVENILE JUSTICE SYSTEM. THEREFORE, FUTURE FUNDING NEEDS TO PROVIDE INCENTIVES AND FLEXIBILITY TO DEVELOP COMMUNITY SERVICES ACROSS SYSTEMS TO SERVE TROUBLED YOUTH AND THEIR FAMILIES. I URGE YOU TO CONSIDER COORDINATING THE PROGRAMMATIC AND FUNDING REQUIREMENTS FOR THESE TWO INITIATIVES.

THERE IS NOW STRONG CONSENSUS THAT THE COUNTRY MUST INVEST IN ITS PHYSICAL INFRASTRUCTURE — ROADS, AIRPORTS AND PUBLIC FACILITIES.

LIKEWISE, WE MUST MAKE THE HARD POLICY CHOICES AND INVEST IN OUR HUMAN INFRASTRUCTURE....OUR YOUTH AND FAMILIES.

MADAM CHAIR, YOUR SELECT COMMITTEE HAS THE OPPORTUNITY TO PROVIDE LEADERSHIP AND DIRECTION.

I LOOK FORWARD TO WORKING TOGETHER WITH YOU TO CREATE A BETTER SYSTEM OF CARE FOR OUR SERIOUSLY "AT RISK" AND TROUBLED CHILDREN IN THE 1990'S.

CLEARLY, WE MUST INVEST IN OUR YOUTH AND FAMILIES TODAY---OR WE WILL CONTINUE TO PAY THE ESCALATING COSTS TOMORROW....IN OUR PRISONS, ON OUR WELFARE ROLLS, AND IN LOCAL MORGUES.

AGAIN, I THANK YOU FOR THIS OPPORTUNITY.

Chairwoman **Schroeder**. Thank you, and, Governor, I wanted to say, and I should have earlier, we are so pleased you brought with you the Director of the Virginia Department of Youth and Family Services who has been putting all of this together.

Governor **Wilder**. That is correct.

Chairwoman **Schroeder**. And we thank you for your hard work that we have just heard about.

I appreciate your pointing out especially this weekend where we got the new statistics on violent crime and how it just seems to be an epidemic in this country. I think you made some very good points, but we are talking about families, and since I railroaded everybody through the beginning of this hearing so fast to make up for lost time, I think what I will do is yield to them to ask questions first if that is okay.

Let me yield first to Congressman Wolf.

Mr. **Wolf**. I will yield to Curt.

Mr. **Weldon**. Thank you, Madam Chairwoman, thank you for holding this very important hearing. Governor Wilder, thank you for joining us.

I am well aware of the success of the Virginia program. I applaud you for your leadership and the leadership of your state in dealing with these difficult problems in these times.

My background is one of an educator. One of the frustrations I experienced as an educator in the public school system and as the chairman of a county government of 600,000 people was a point that you have referenced today, the same child being dealt with simultaneously by a number of agencies. One of the things I think you have alluded to that perhaps we can assist you in is trying to provide better coordination within our schools among the various agencies. We should be coordinating the services of the juvenile justice system, the child welfare system, the family and community service agencies, as well as the mental health agencies.

One of the things we tried in my own district in Pennsylvania was to place an individual in the school as an ombudsman, whose responsibility it was to coordinate the service deliveries for the children.

The other point you referred to that I invite you to expand upon is your comments about federal funding. Is it your view that the federal government has mandated certain steps in the educational process for special education students, but is seriously behind in terms of meeting the funding requirements that were promised years ago?

I believe that number was supposed to be approximately 40 percent of the funding. I do not know what the case is in Virginia, but is this a problem that you are experiencing in your state?

Governor **Wilder**. Precisely, and the problems with special education, as you know, vary individually and they vary even from school to school, but the problem that you have just addressed is that the funding has not been made available, and consequently localities will say, "We are not going to do anything unless the state does its share," and if we slack off at all with our share because the federal funds have slacked, nothing would be done, and it is a very, very serious problem.

Mr. **Weldon**. This is true in a number of areas. When we establish mandates at the federal level for the states and the counties, and then the funding that was committed at the time the legislation was passed is not provided. That causes tremendous hardship and frustration locally.

Another problem that we had in Pennsylvania in my county which I would like you to comment on, was the lack of flexibility in terms of mental health and mental retardation funds. Should the federal government provide more flexibility to the states and the localities in determining the proper mix and use of those dollars?

Would you also agree that that is something that perhaps we should look at?

Governor **Wilder**. Yes, that is. I referenced it earlier. In the absence of that degree of flexibility, you are constricted, and wherein you would have a pool of funds for one thing, but none for the other, so you will not be in a position to have the interagency transfers as we have described, and it is not only a problem, but it causes the turf battles that causes that same child to be bounced around like a ball, and it is frustrating.

I used to on occasion represent, when I lived in another life, parents who had their children to take them to court, and it was just frustrating for me to understand where I could go, and I was a lawyer trying to find out how to find some help for this parent.

These were parents who were working, who were interested. They were not receiving federal assistance or state assistance. All they wanted was help, and we could not find it in the schools. Some of the schools would say, "Well, we cannot do it because we do not have the funds for this."

When we go to the courts, sometimes the courts—we have it in our courts—is the sum sufficient, and the court says, "Well, I will tell you I am not going to keep on putting up with this. I will tell you what I will do. You handle it." Well, that might not be the best place for that child, and we do not have the flexibility.

It is a very serious problem.

Mr. **Weldon**. Thank you. Governor. I yield back any remaining time.

Chairwoman **Schroeder**. Thank you.

Congressman Miller.

Mr. **Miller**. Thank you, Madam Chairman.

Governor, welcome.

Governor **Wilder**. Fine. Good to be here with you.

Mr. **Miller**. Thank you for your participation this morning. I think that your testimony is very helpful.

I think it is becoming more and more clear certainly to Governors faster than to those of us at the federal level, that the categorization of these children at the local level is now becoming an impediment to the services that we desire to deliver to those children. A number of areas across the country are struggling, as is Virginia, with this effort.

And you are to be commended because I think that as the states, and my own State of California is about to embark as a result of budgetary problems much like Virginia's on a new effort at the county level, start to build an interagency model, a model of coordination, a model of protections, I think the comfort level at the federal level is going to rise dramatically in terms of our willingness to think about flexibility in the fundings across juvenile justice moneys and mental health moneys and probation moneys, and all of the problems that we have.

I think that Virginia can clearly lend a great force to that argument.

Let me just raise one point. You mention, and maybe the director might chime in on this; you mention that you would like to remove the restrictions on foster care IV(e) funding to pay for services. I assume this is part of the debate now about administrative costs. As states and counties are determining that they want to engage services on behalf of a child prior to placement, those are being charged as administrative costs because that is the only way to get these services reimbursed. The federal government is now worried about the dramatic increase in administrative costs which they thought involved processing the papers as opposed to the provision of services.

What you are really talking about though is looking at a family in trouble and seeing what you might do prior to the placement of that child because IV(e) just simply pays for placement, and God knows what happens to the children after that.

So this distinction between whether it is administrative costs or services or not, you would disagree with that, I assume. You simply want the flexibility, whether it is IV(e) or increases in IV(b) services money, to move that money back and forth on behalf of the child; is that correct?

Governor **Wilder**. That is correct.

Charles, you might want to speak to that.

Mr. **Kehoe**. Yes, I think that is correct. The issue is that the emphasis now is currently on out-of-home placement, and the dollars all flow in that direction. Given restructuring of that and a redirection of those dollars more towards prevention, early intervention in families, family-based services, we can obviously do more effective work with the families for basically a very nominal increase in those dollars.

Mr. **Miller**. That law has requirements in it. I wish it required that placement take place as close to the proximity of the child's home and all that is necessary, but that is not a mandate that seems to be required. I think I agree with you that what, in effect, happens is those dollars drift towards the most intensive placement and restrictive placement of those children rather than part-time placement in the community or out-of-home services. Those kinds of efforts simply do not seem to be a priority with the allocation of those funds.

Is that what you find in Virginia also?

Mr. **Kehoe**. Yes. I think the issue there has to do with availability of programs, and then the youngsters' eligibility for those funds, to begin with, and trying to find where the available placement is oftentimes may, depending, move the child further and further away from home in order to accommodate the service plan for that individual youngster.

So it is not necessarily always that we are trying to keep things within the youngster's community.

Mr. **Miller**. Governor, I think you raise a very telling point when you, in your testimony, point out to us that when you looked at 14,000 names in the system, you really had 4,900 children.

I just went through this last week with the county that I represent. They started outlining to me the amount of time that they were spending asking the same people their names, addresses, numbers of children, social security numbers, and so forth, and in fact, they were dealing with the same families.

I mean there has got to be a way, and apparently there really is none in the entire country. I think there is one program in the Central Valley of California that deals with a central registry of these families and children so that you can, again, focus those services on those families and children instead of continuing to believe that this is the first encounter.

It is not the first encounter.

Governor **Wilder**. That is right.

Mr. **Miller**. It is the first encounter maybe with that intake worker or service provider or department, but we know now that those children and families have been around that system much longer. I think you make a very important point for those of us at the federal level.

Again, when it comes through a categorical point of view, very often we have competing interests trying to get money to fulfill their obligation. Properly so, but we are still talking about the same children at the other end of the funnel.

Governor **Wilder**. And you have got to eliminate the turf battle.

Mr. **Miller**. If you can do that, Governor, let me tell you we will all vote for you for President. [Laughter.]

That is the toughest job there is. I think that is what we are waiting to see, whether or not Governors can start to be successful in doing that because that will change our whole approach.

Governor **Wilder**. Well, that is what we are doing in terms of interagencies, is cutting through it right from the beginning because some of these children we are referring to or individuals, even though you are talking about 4,900 of the 14,000 names, they did not just all start there. Some of them have been there for years.

This one may have had it four years. This other one comes up, "Well, we did not get it but a year later," because the ball did not bounce into their court until that particular time. So it is a very serious problem. We are working on that.

Mr. **Miller**. Well, we look forward to it. As we know, you can squeeze a lot of resources out of these systems by coordination and cooperation and get a better focus on those, but at some point we are going to need additional resources.

Governor **Wilder**. That is right.

Mr. **Miller**. Because even for those 4,900 children there is such a mismatch between the real customized services that these children and families need, and what they get.

Thank you.

Governor **Wilder**. Thank you.

Chairwoman **Schroeder**. Congressman Barrett.

Mr. **Barrett**. Thank you, Madam Chair.

I, too, Governor, appreciated your comments very much. I have had an opportunity to at least scan the recommendations and the actions taken by the State of Virginia, and I appreciate that very much.

As a former speaker in a state legislature, I can identify very quickly with some of the problems that you have identified, and also as a person who had a great part in passing one of the nation's, I think, premier foster care review board laws, you have already identified previously my big concern on funding, but do you in Virginia now have a foster care review system to track these kids that are lost in the system that you have just now touched on?

Mr. **Kehoe**. Not in the formal sense that you have described it in other jurisdictions.

Mr. **Barrett**. Has this been under consideration at all in the State of Virginia?

Mr. **Kehoe**. Yes, it has. The Department of Social Services, that is one of the issues that the Department of Social Services is considering as part of this overall plan.

In fact, the overall plan requires a much more global look at all youngsters in out-of-home placement so that it is now in demand of social services, of mental health, of juvenile justice and of education, as well.

We do have a rate setting council that also looks at all of the youngsters in placement and establishes uniform rates for the provision of services to young people.

Mr. **Barrett**. Services including payment to foster parents?

Mr. **Kehoe**. Oh, yes.

Mr. **Barrett**. Okay. Thank you very much.

Chairwoman **Schroeder**. Thank you.

Congressman Smith.

Mr. **Smith**. Thank you, Madam Chair.

Governor Wilder, I, too, want to add my thanks for your taking your time to be here today.

You used the phrase a few minutes ago in your opening statement "effective use of diluted resources," which is, of course, a phrase we have heard you use before and which I happen to agree with. You mentioned the figures in Virginia. You spend $100 million to help just fewer than 5,000 youth, which comes out to be about $20,000 per child, which happens to be more than the cost of any private school in Washington, D.C.

I gather you think that $20,000 is not an effective use of limited resources.

Governor **Wilder**. You are right. The other day I was asked the question to sign an order which would permit one of our agencies to dip into next year's allocation for funds. It is not going to be a deficit, but they know they could make it up, and I was getting ready to do it and looking around, and I saw the cost for one child's placement to be $61,000. I said, "Good golly." So I said, "What went on? What did you do?"

And they said, well, you know, it was a very special case. I said all right. I saw another one that was $40,000. I said, "What happened to this one?" This one was very tough. Then it varied, as the Chairman indicated earlier. We have some as low as $3,000 in the community-based home, and that range is just unacceptable.

Then I wanted to find out even with limited resources, even if we had all the money in the world are we getting the best bang for our buck? Is this what we can expect in the future?

For instance, let's assume that the child was borderline and did not require being in an institution or the intensive care, and the parents were there, not state government or anything else. What would be the cost?

And then to take it from that level to see then what are you doing. Is it for shelter? Is it for psychological testing? Is it for speech therapy? Is the child capable of learning? It is a very difficult thing when you get there.

One of the problems we had, and it follows up with Congressman Barrett's question, when you have the review panel that reviews the cost, in many instances it is made up of the people who protect the turf, and that makes it somewhat incestuous. It is very much a part of the problem.

So you are going around in circles when you try to grab it, but in lean times, it gives you an opportunity to really assess it and say, "Now, let's all come together and see what we can do," and it is a very troubling situation.

Mr. **Smith**. Governor, you and I have corresponded a couple of times about the idea of cutting overhead costs in order to have a more efficient government.

Governor **Wilder**. Yes.

Mr. **Smith**. I gather you think that overhead is also an area that ought to be looked upon to avoid some of the bureaucratic expense, and not just the bureaucratic hassle of running those types of operations.

Governor **Wilder**. Yes, and I am very pleased to say that the administration has been very cooperative in that regard. Our people have, especially in social services. We found in one particular area, and I will not define the city or location—and I love PR people. Don't misunderstand me. I do not want anyone in the room to get me wrong, but this particular social service agency had six PR people, six, and our Director said, "There is no need for that," before I could even say anything about it. He said, "We will cut that," and that is an administrative cost that, indeed, could be replicated in other areas that we need to get rid of.

Mr. **Smith**. So there are ways to cut.

Governor, I have one last question, and that is: would you speak a little bit about what you consider to be some credible alternatives to the system that is being used right now, and particularly in regard to individuals, whether they might be foster care programs or some other program like that?

I guess I have a special interest in this, and I think it is also a way, frankly, for you to suggest to individuals how they might help out in their own communities.

Governor **Wilder**. Well, the earliest possible intervention, when you see the difficulty taking place, and as Mr. Kehoe has indicated, before you speak of placing the child or taking the child out, go into the home and see what can be done.

Many times the parents need help. Many times you are dealing with parents themselves who are traumatized in one form or another, and especially with teenage parents or younger parents or parents who for whatever reasons have been disadvantaged, and their counseling. In many instances counseling with those parents could do so much to help the children, and the children sometimes are just as sound as dollars, but the parents, in terms of their reactions with them.

So we could have what some would say are neighborhood groups to be involved. We have had private sector people do it in work counseling, but if we could have more community-based opportunities and volunteers who would come forth to understand that the primary purpose of being there is to assist the child because no parent wants to be told that they are not capable of dealing with their child, even though that parent will come and say to the judge or to the principal or to the school teacher, "I cannot handle him. It is your problem. You take it."

But we need to reverse that and to say, "No, we will help you deal with that problem."

Mr. SMITH. Thank you, Governor.

Governor WILDER. Thank you.

Mr. SMITH. Thank you, Madam Chair.

Chairwoman SCHROEDER. Thank you.

Congressman Wolf.

Mr. WOLF. Thank you, Governor.

I agree with just about everything you have said. However there are two problems. One is the administrative costs. No one seems to have a handle on that. Maybe the committee ought to get the General Accounting Office to do an investigation across the country to see the administrative costs in all of the different States. The second problem is directng Federal dollars to provide preventive and early intervention services.

It seems to me that one of the great problems is clearly people that are in the system now have to be helped, and we have to do everything we possibly can to deal with these problems in a very aggressive way. Although it will be costly, I think we have an obligation.

I think it is equally important to focus on strengthening the family. If you can get to the family in the beginning and help to make some minor adjustments, you can really help to solve the problem.

When you look at some of the indicators, you know, spouse abuse is up. Child abuse is up. Teenage pregnancy is on the rise.

Governor WILDER. Dropouts.

Mr. WOLF. All of these indicators are going up. So I think the more the state and the federal government can do to remove the burden on the family and let the family deal with these problems, the better off they will be.

I have a bill with 92 co-sponsors. Obviously when we first put it in we did not know how popular it would be, to increase the personal exemption for children in the tax laws. Currently the personal exemption is $2,050 per child. We would increase it to $3,500 per child, with the idea of letting Moms and Dads have more of their own money so they can make family decisions. The bill will take some of the financial pressure and burdens off of the family.

So I salute your comments, but I think the more we can do to intervene early, the better off we will be.

Governor **Wilder**. And I think it requires a coordinated effort with the state, federal and local governments. It is absolutely important that we settle that turf rather than just speak of the interagency turf and the people who are protecting job turf or professional turf.

If the direction is given from the federal government to the states, if the mandates are matched with dollars, and if the flexibility is allowed the localities and the states to address the program to achieve the result, rather than to go through steps that might not achieve the result, I think we would be better off.

Mr. **Wolf**. Why do you think there are so many mandates at the federal level? Do you think it is a lack of trust or something else?

Governor **Wilder**. I think it may very well have originated that way earlier, as to what some localities or states would do with the funds, but I think now that the public has understood that the need is there, and we all see it, I do not think that that would be a factor as much as it may have been in the past. I do not think it is lack of trust. I think it is a lack of revision, a lack of the need to see that it has to be changed, and that is why we are here today.

Mr. **Wolf**. Thank you, Governor.

Governor **Wilder**. Thank you.

Chairwoman **Schroeder**. Well, I want to thank you, too, and I think you just put it in context. We have got two kinds of turf wars going on. We have got the vertical turf war between all of the different levels of government, and the horizontal on each level.

Because, you know, when you have these hearings, it makes such sense, and you begin to think, "What in the world?" And it has been going on for 20 years trying to get hold of this thing.

I thought your comments about the door the child comes through is the door that defines the services that child will get, were right on point. That is absolutely ridiculous.

I want to use the expertise of the Director, Mr. Kehoe, because my understanding is your background is in juvenile justice with juvenile offenders, and I know as I look at different state budgets, including mine in Colorado, one of the biggest things we are spending money on is more and more prisons, and that is not exactly what you want to see as the new growth industry in America.

Are you aware or are there mental health treatment services available for children in any of these juvenile correction systems around the country?

Mr. **Kehoe**. Yes, there are a number of different systems that are developing strong mental health components. One that I am familiar with that has a very strong mental health component is the Illinois system that has really worked for a number of years to initiate good, strong mental health services for the kinds of youngsters who need to be incarcerated. These are serious felons, youngsters who represent a risk to society.

We, in Virginia, are working very closely with our Department of Mental Health allowing strategies for helping us to institute services within our system, as well.

One of the things, I think, that is important is to understand that while we need to work very closely together, the two systems do have separate initiatives. Ours, the juvenile justice system, does have to put emphasis on custodial care and protection to the public and minimizing escapes; whereas, mental health needs to work more towards the integration of youngsters into the communities and to work with their mental health needs.

What we need to be able to do through cooperation is to blend those two agencies together so that when we have youngsters who may represent a risk to the public safety, but who have mental health needs, that those youngsters are going to get those services and hopefully then be able to be less of a risk to society when they return to the community.

But that is one of the major ones. Massachusetts, I think, has also been doing some very innovative things in working with the private sector along the lines of establishing a broad base of mental health services. So there are a number of states where this is going on, and it seems to be very encouraging.

Chairwoman **Schroeder**. I know one state I talked to said that as they did this, they found 25 percent of the workers quit. They could not take the turbulence and the constant changing of orders and how they were going to do things, the new way of looking at the young person in a more holistic fashion. They just were not able to cope which I thought was very interesting. We have gotten so used to compartmentalizing.

Have you found a lot of opposition in Virginia to what you are trying to do?

Governor **Wilder**. No, I have not felt it on the Third Floor, and I do not think Chuck has found it. As a matter of fact, what we have found is that it is almost like a tacit acquiescence, that people have somewhat been waiting to find the direction, and they welcome it.

And accordingly, from the counselors, from the courts, and from all the people we have occasions to come in contact with, they are encouraging us to do more, and that is why I guess we feel that what we are doing is just a start in the direction that we want to finish, and to capitalize on the experiences of other states and to learn from what other people are doing.

But, no, we have not had any objections.

Chairwoman **Schroeder**. Well, that is good, and I think early intervention is really the way to go, as Congressman Wolf said, because it is so much cheaper than institutionalization forever and ever.

Governor **Wilder**. Oh, yes.

Chairwoman **Schroeder**. I also think, too, a lot of the more routine mental health needs are not even being dealt with. We are talking about the very extremes here, and I think the increase in the number of suicides and those types of things that we are seeing among young people, I just do not get at all, but we really need to work very hard on that, too, but I guess we have to start at the more extreme and then start working down and talking about it more.

I guess there is more optimism among kids. If you can get them earlier, you can do a lot more for them, and it seems to me it is money well spent, if we can just figure out how we coordinate it and do it.

So thank you so much for coming.

Governor **Wilder**. Well, thank you.

Chairwoman **SCHROEDER**. And we realize it has been a tough day to get here, and we really thank you for your attention to it.

Governor **WILDER**. Well, I have enjoyed it, and thank you, and I hope that we, as I said earlier, can continue to work together. Thank you very much.

Chairwoman **SCHROEDER**. We really look forward to it. Any ideas you have for us at any level, let us know.

Governor **WILDER**. Thank you.

Chairwoman **SCHROEDER**. Thank you very, very much.

We now have a very distinguished panel that also had a lot of trouble. It has been a day where we have had trouble getting all of our panel here. It has not been easy for anyone.

First let me introduce Barbara Huff, who is a parent and the President for the Federation of Families for Children's Mental Health, from Topeka, Kansas, where I think everyone is aware had a very unique week. We are very sorry about all of the things that have gone on in Kansas this weekend and appreciate the incredible effort that you have made to be here.

Lenore Behar, Dr. Behar, is a Special Assistant for Child and Family Services in North Carolina, in Raleigh, North Carolina, and we are very, very pleased that you could be here this morning.

Clifford Attkisson, Dr. Attkisson, is a Professor of Medical Psychology at the Department of Psychiatry and the Associate Dean of the Graduate Division of the University of California in San Francisco, and we truly appreciate that.

Dixie Jordan, who is a parent and advocate for Parent Advocacy Coalition of Educational Rights, from Minneapolis, Minnesota, and we understand that it has been a very difficult weekend for Dixie to get here, too; that there have been all sorts of personal things that came up in her life.

Dr. George Rekers, who is the Professor of Neuropsychiatry and Behavioral Science and the Chairman of the Faculty in Psychology, University of South Carolina School of Medicine, from Columbia, South Carolina. We are very, very pleased to have you.

And Congressman Weldon would like to introduce someone from his district who is very special among this panel, too. Let me yield to Congressman Weldon.

Mr. **WELDON**. Thank you, Madam Chairwoman.

It is my distinct honor and pleasure to have today as a witness someone who is eminently well qualified and experienced working with children with mental health problems. Dr. Sandra Cornelius has been the Director and Administrator of Human Services of Delaware County for the last eight years, where she has done an outstanding job. Most recently the county was awarded a Robert Wood Johnson Foundation Grant. The grant will bring approximately $1.5 million for the coordination of the delivery system in our county, with a very heavy emphasis on involving the private sector and the better coordination of public sector funds.

Most recently Dr. Cornelius has been named the President of the Elwyn Institute. As many of you may know, Elwyn is the largest and oldest private facility for the disabled in the nation. Elwyn serves internationally as a leader in providing education and rehabilitative services. Elwyn serves over 10,000 children and adults annually with mental and physical disabilities. Their facilities are primarily located in my district, but also at 40 other locations, including California, Delaware, New Jersey and Israel.

Elwyn has a broad approach to dealing with mental health and mental retardation problems. The school focuses on community programs and community living arrangements. Dr. Cornelius has had experience both in the public sector and now in the private sector as the President of Elwyn. So it is a pleasure to welcome you, Sandy, to this hearing today.

Chairwoman **Schroeder**. So if the panel will please take their seats, as I say, it has been a very, very interesting day where we have had traffic in Northern Virginia, tornadoes in Kansas, personal problems and everything else. So it has been a panel that has persevered at all costs, and we truly appreciate it. I think that shows your dedication that you all made it.

We will put all of your statements in the record, and what I think we will do is just begin and go right down the group. Each of you can summarize as quickly as possible so we can get into questions and answers if that is possible.

So let me start with Barbara Huff. Barbara, the floor is yours.

STATEMENT OF BARBARA HUFF, PARENT AND PRESIDENT, THE FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH, TOPEKA, KS

Ms. **Huff**. Thank you, Madam Chairwoman and members of the committee, for this opportunity to be here today, and I will try to be brief with my comments so that you can ask questions, and please remind me if my five minutes is up, okay?

I think it is most important today that I represent the fact that I am a parent of a daughter with serious emotional problems. She was identified when she was six years old as having a learning disability. We are from Wichita, Kansas originally, and when Kristin was 11, she was diagnosed as having lipoid nephrosis, which is a serious kidney disease, and by the time she was 12, she had serious attempts at suicide and all kinds of emotional problems, and at the age of 14 was diagnosed with severe anorexia.

So I have had a first-hand opportunity to know what it has been like to be a parent of a child with serious emotional problems. And I would tell you that out of all the systems that we worked with, education, mental health, health, the most difficult was Mental Health Services. Not only was there none available, nothing between a 50 minute mental health center visit and an institution bed. It cost our family $2,000 a month for her mental health services at KU Med. Center in Wichita, and financially exhausted every resource we had, and we were an upper middle class family.

We were divorced through that period of time, and our oldest daughter who is 19 months older than Kristin suffered from serious bouts with depression as a result of it all. So a little later on it finally kind of showed up in her life.

So it had been recommended to us several times to institutionalize her. It would have meant relinquishing custody to the state. It would have meant going up in front of a judge and saying, "I do not want this child any more," and that was the only way to get around the exorbitant financial cost with this child.

We put a second mortgage on our home, sold absolutely everything we had, and are still paying for the services for her, and I just think that the isolation that we felt, the financial exhaustion that we felt, the hopelessness that we felt we will probably as a family never recover from.

That was the sole reason, I think, for my commitment as an advocate, are some of those emotional feelings that I felt, that I kind of promised that other families in this world would not have to go through what we went through as a family.

The beginning of the national organization that I represent and speak on behalf of today, the Federation of Families for Children's Mental Health, was really started based on that. I began to be more educated as a parent and to understand the system better and to understand how our money flows, and that money does flow into out-of-home placements, and that is why our child was recommended for that; and that there are no services in between.

Our family needed things like respite. We needed someone to case manage these systems that we were working with. We needed somebody to help us in a crisis at 12:30 at night when this child was ready to commit suicide.

We exhausted our Blue Cross/Blue Shield within the first hour at KU Med. Center. We had a $500 deductible policy. So that is why we were on our own with this. I mean we had paid $400 a month for that kind of family policy to be exhausted within the first couple of hours.

So in realizing the isolation, knowing exactly what families deal with, I became involved with our CASSP Child and Adolescent Project in Kansas, Service System Program, and as a result of that, I began to go to some meetings at the national level and met other families, other parents, other moms, and realized that what I was going through was no different than what other families were going through, and suddenly we began to talk about what needed to happen at different levels than just our own local level and state level, and it was based on some of those initial meetings that we began to get together more frequently.

I listed for you on the second page of my testimony some of the history of the Federation, and I will not go through all of that other than to tell you that in December of 1988, it was the first opportunity that about 80 of us got together. It was a tremendous emotional experience with families saying we have got to do something different. We have got to have something for our kids. We have got to be able to work this at a national level. It is not working at the local and state level.

And it was based on that that we identified five major areas of concern, and those concerns at that point in time are still concerns today: appropriate educational services for our children; the need for community-based services, mental health services; a real variety, a whole array of services in the community for our children; and the need for agencies to coordinate these services; the need to have access to the services without relinquishing custody of our children; and to be able to have support for our families.

With that in mind, the Federation had our second meeting after that. It was decided at that meeting what the next steps would be, and I followed that on this page and began to tell you what the history was.

We have engaged in some advocacy efforts. We have been working really hard to do that, and I think we are beginning to see some results in that our membership is 400-500 now. Actually I think it is over 500, and it is an exciting opportunity to see that this sole voice for children that have serious emotional, behavioral and mental disorders is working, and that is exciting also.

And I also enclose because I think it is important for you to know the next couple of pages, which are our philosophy statements. This is what we believe in, what we believe should happen.

So that gives you a little bit of background about myself as a parent and this new organization, the Federation of Families for Children's Mental Health, and before I finish here, I would just like to say to you, Madame Chairwoman, and especially to Representative Miller, how much we appreciate your effort here not only today, but I know Representative Miller has been very, very instrumental in this new piece of Federal legislation.

I also know that you have signed onto that legislation as a cosponsor, and we appreciate that immensely, and it is a pleasure to meet you all today because I have heard so much about you.

So thank you again for this opportunity.

[Prepared statement of Barbara Huff follows:]

PREPARED STATEMENT OF BARBARA HUFF, PRESIDENT, FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH, TOPEKA, KS

How did an interior designer from Kansas end up as an outspoken advocate for children's mental health issues and the President of a national organization? According to the road map, it's only 200 hundred miles from Wichita to Topeka, but the road from there to here was not straight, and certainly not smooth.

My involvement began when Kristin, my youngest daughter, was identified as having a learning disability at age 7. When she turned 11 she was diagnosed as having Lipoid Nephrosis, a blood disease affecting the kidneys. At age 12, she became suicidal, was severely depressed, and was diagnosed as having anorexia nervosa at age 14. My advocacy efforts began as a direct result of my inability to find services to help my own child.

Kristin's life was touched by several systems including education, health and mental health— none of which worked together or provided a system of care necessary to support her or our family. We had difficulty locating available services and waited as long as four weeks to be seen by our mental health agency only to be told that she was too serious and we would need to find alternative treatment. They advised institutionalization which would have required us to relinquish custody of her to the child welfare system. We were devastated and called the mental health association who referred us to another parent in our area who had a child with anorexia. She referred us to KU Med Center where we waited again for six weeks for an appointment. Kristin's weight had dropped to 76 pounds and her days were spent doing excessive amounts of exercise—over 500 situps a day and riding 20 miles on an exercise bicycle.

The cost of entering KU Med Center for outpatient therapy was $2,000 per month. Our only alternative to a 50 minute mental health visit was an out of home placement. We were an upper middle class family whose resources were exhausted. After three long years Kristin began to show improvement however the cost was great. Her father and I were divorced, her sister was beginning to show signs of severe stress, and I was on the verge of a breakdown. We had not had the needed services, especially crisis services, respite, case management ,or support for our family. What services we did have were not coordinated. Professionals continually blamed us for her problems and provided no real solutions. The fact is there is no system of care that provides family centered services for children in their home community, nor provides families with available, affordable and flexible services for their children.

In 1987 I assisted in starting the first parent support group in Kansas for families who had a child with emotional problems. The support group was the catalyst for the formation of a state wide organization in Kansas. I am currently the executive director of Keys for Networking. Our organization provides information, support, training and advocacy for families who have child with emotional disorders. As we were organizing our statewide movement other states were also in the process of engaging families in support efforts which provided the impetus for the establishment of a national organization. While my story is unique to our family it is not unlike the stories of the 7.5 million families across this country who have a child with a serious emotional, behavioral or mental disorders.

A BRIEF HISTORY OF THE FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

1986 — Portland State Regional Training Center sponsored the first Families As Allies conference. One of the ideas raised was the possibility of a national organization dedicated to children's mental health issues.

January 1988 — Arrangements for a group of 8 parents, representing various areas of the country, to meet with Madeline Will and Patty Smith , of the U.S. Department of Education, to discuss at length the major issues facing families of children with emotional disorders. The idea of a national organization surfaced again, and the participants were encouraged to move toward it's creation.

December 1988 — The Portland State RTC conducted a conference in Alexandria, VA, to set a national agenda for children's mental health. Five major issues of concern were identified: the need for appropriate educational services; the need for community-based services; the need for agencies to coordinate these services; the need to have access to these services without relinquishing custody; and the need for family support. Eighty parents met to determine what the next step should be. The majority of families present decided to form a Steering Committee, and meet again to decide what actions should be taken.

February 1989 — The Steering Committee met and voted to form a national parent-run organization, speaking only on behalf of the needs of children with emotional, behavioral and mental disorders. The Steering Committee, representing 16 states, became the Interim Board of the fledgling Federation.

Next Steps, 1989 — The Interim Board met again in March, June, and September. The Federation has been incorporated in the State of Maryland; By-Laws have been adopted; and application was made for Federal tax-exempt status under 501(c)(3); and became more and more involved in Federal policy issues. The following mission statement was adopted:

- to provide leadership in the field of children's mental health and develop necessary human and financial resources to meet it's goals.
- to address the unique needs of children and youth with emotional, behavioral, or mental disorders from birth through transition to adulthood.
- to ensure the rights of full citizenship, support and access to community-based services for all children and youth with emotional, behavioral, or mental disorders and their families.
- to provide information and engage in advocacy regarding research, prevention, early intervention, family support, education, transition services and other services needed by these children and youth and their families.

1991 — We are presently a national organization with a membership exceeding 500. We aim to develop a cohesive, enduring union of groups and individuals who will articulately and effectively speak with one voice to policy makers, professional organizations , legislators and the general public solely about the needs of children with emotional problems, and their families.

Attached is the Philosophy Statement of the Federation of Families for Children's Mental Health.

THE FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH

PHILOSOPHY STATEMENT

The Federation of Families for Children's Mental Health, Inc., is founded on the following principles:

CHILDREN AND ADOLESCENTS WHO HAVE SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS ARE PEOPLE FIRST.

- Children and adolescents with serious emotional, behavioral, or mental disorders must be viewed as people first and not merely seen as a disability.

- Written and spoken language must always refer to "children or adolescents with emotional, behavioral, or mental disorders" rather than "the disturbed" or "disturbed children."

CHILDREN AND ADOLESCENTS WHO HAVE SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS COME FROM A BROAD SPECTRUM OF FAMILIES WHO HAVE A VARIETY OF STRENGTHS AND NEEDS.

- Inflexible policies and practices of the different systems that serve this population of children must become flexible in order to meet the families' range of needs and resources.

- Inflexible policies and practices create unnecessary stress and overwhelming responsibilities for the families of children and adolescents who have serious emotional, behavioral, or mental disorders. It is not the children per se that create the stress.

- Families are often misperceived as being "dysfunctional" when they are experiencing normal reactions to the serious lack of appropriate, accessible, and affordable services and supports available to them.

- The term "dysfunctional families" is blaming and unnecessary and must not be used in written or spoken language.

THE CHILDREN OR ADOLESCENT WITH AN EMOTIONAL, BEHAVIOR, OR MENTAL DISORDER IS A MEMBER OF A FAMILY.

- Throughout his or her life, an important constant will be the support of and relationships with the family. Because of the nature of the child or adolescent's disorder, professional support will be needed and provided. These services are in addition to the family structure.

- The services may be short- or long-term, but they are time-limited, especially if the child or adolescent is in a residential or hospital treatment program.

- If the child or adolescent is in a residential or hospital treatment program, the length of stay must be determined by the child's or adolescent's progress and improvement and not by time-limited funding mechanisms.

- Regardless of where the child or adolescent is living, he or she always remains part of the family. If an out-of-home placement is necessary, diligent and conscientious team planning for a successful transition home must begin immediately.

PARENTS MUST ALWAYS BE VIEWED AS TEAM EXPERTS REGARDING THE CHILD OR ADOLESCENT'S WELFARE SINCE THEY HAVE 24-HOUR, 7-DAY-A-WEEK LIFELONG EXPERIENCES.

- Decisions which affect the life and well-being of the child or adolescent should remain in control of the family.

- Parents must have a voice and a vote on any decision-making team concerning the child or adolescent.

- Parents and family members must assume some of the responsibility for becoming informed regarding the choices and options for children and adolescents with serious emotional, behavioral, or mental disorders.

- Professionals have an obligation to provide family members with up-to-date information on rights, services, programs, and other options available.

FAMILIES AND PROFESSIONALS MUST RESPECT THE INDIVIDUALITY, RIGHTS, AND STRENGTHS OF CHILDREN AND ADOLESCENTS WHO HAVE SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS.

- The child or adolescent should have a voice and a vote on any decision that affects his or her educational, mental health, or vocational rehabilitation program or treatment.

- Children and adolescents with serious emotional, behavioral, or mental disorders should be encouraged and assisted to learn about their rights, choices, and the service options available to them.

- Professionals have an obligation to provide accurate information on rights, services, and available options to children and adolescents with serious emotional, behavioral, or mental disorders.

SERVICES PROVIDED FOR THE CHILD OR ADOLESCENT WITH A SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDER MUST EMPHASIZE THE IDENTIFICATION OF STRENGTHS.

- Services must focus on the strengths of each child or adolescent, taking into consideration deficit areas.

- Any professional assessment of children and adolescents with serious emotional, behavioral, or mental disorders must include the use of a range of comprehensive testing instruments.

- Assessments must include elements that address the cognitive, emotional, social, and physical capabilities of the child or adolescent.

SERVICES MUST BE AFFORDABLE, ACCESSIBLE, AVAILABLE, AND APPROPRIATE.

- All treatment options must be explored and identified, and all available services must be listed for families.

- The goal of all services must be to enable the young person to live, work, and play in his or her community.

- Services must be flexible and individualized to meet each family's unique needs and situations. Programs must adapt to families; families must not be forced to fit into preexisting program molds.

- Funding mechanisms must be supportive of rather than destructive to families by allowing for services to be provided in individualized, flexible ways that meet the unique needs of each family.

- Natural families are entitled to the same in-home community-based support services and programs that are offered to foster families who elect to care for children with serious emotional, behavioral, or mental disorders.

FAMILIES HAVE MANY WAYS OF ADAPTING TO THE NEEDS OF THEIR FAMILY MEMBERS.

- Support services, such as: parent-to-parent discussions; advice from professionals; in-home or out-of-home respite care; and/or individualized services that are discussed and planned in team meetings must be available and accessible to families.

- Families are entitled to a range of support services that will enable them to keep their children and adolescents at home rather than have to place them in out-of-home treatment programs.

- The child or adolescent is a member of an intricate family structure and assistance to one family member may serve to support other family members, if not the entire family.

- The family may benefit from advocacy efforts, and families should be encouraged to learn about the range of advocacy options available.

- Professionals must respect the diversity and varied experiences of families. Therefore, professional schools must provide training to students on how to collaborate with families and how to advocate effectively. Parents and other family members should be involved in the training of professionals.

FAMILY UNITS ARE A SOURCE OF STRENGTH FOR YOUNG PEOPLE WITH SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS.

- All families are knowledgeable about and resources for their own children and adolescents.

- In families where there is abuse or neglect, the child's or adolescent's well-being and safety must be the primary concern. In these situations, recognition must still be made of the family's strengths and intensive support must be provided so that the child might safely remain with the family.

- Removal of a child or adolescent from her or his family home must be seen as the last resort.

- Family reunification is the main goal after any move from the home takes place. Efforts to achieve this must begin immediately.

- When family reunification is not possible after all options have failed, another permanent family situation must be found for that child or adolescent.

SERVICES TO THE CHILD AND SUPPORTS TO THE FAMILY MUST BE PROVIDED AND BASED ON NEED, REGARDLESS OF THE FAMILY'S ABILITY TO PAY.

- The location, quality, and/or frequency of services that are available and provided to children and adolescents with serious emotional, behavioral, or mental disorders must be based on the individual's need for services and not on the ability to pay for the services.

- The quality and/or frequency of supports that are available and provided to families whose children and adolescents have serious emotional, behavioral, or mental disorders must be based on the need for the supports and not on the ability of the family to pay for them.

THE TRAINING OF PROFESSIONALS WHO WORK WITH CHILDREN AND ADOLESCENTS WHO HAVE SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS MUST BE IMPROVED.

- High quality, well-qualified personnel must be recruited to provide the special education and related services needed by this population of children and adolescents.

- Appropriate professional standards should be developed for providing services. There needs to be a sufficient number of personnel preparation programs that will meet appropriate, professional recognized standards.

- State-of-the-art methods, strategies, and materials for working with this population of children and adolescents and their families need to be identified and disseminated.

- More training and education programs are needed for professionals who directly work with this population of children and adolescents with, or at-risk for, serious emotional, behavioral, or mental disorders.

- Parents, regular educators, service providers, and community groups also need to be involved designing, conducting, and evaluating the training.

- Professionals should receive training in the delivery of interdisciplinary services and in working with families in collaborative ways.

- Greater efforts need to be directed to the recruitment, preparation, employment, and retention of professionals who are members of minority groups. There also need to be assurances that all professionals who provide services to this population are trained to be sensitive to the unique needs of culturally diverse children and youth.

- Parents need training and information that will support them in their roles as active, informed decision-makers for and with their children and adolescents who have serious emotional, behavior, or mental disorders.

FAMILIES AND PROFESSIONALS MUST DARE TO HOPE AND DREAM ABOUT WHAT MIGHT BE FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL, BEHAVIORAL, OR MENTAL DISORDERS.

- Families must recognize their own strengths and the strengths of their children and adolescents and build on them for the future.

- Professionals must recognize that each family and each child or adolescent has capabilities and strengths. It is up to professionals to guide families in identifying and utilizing their strengths.

- Families and professionals must collaborate to improve not only the services and programs available to children and adolescents but also to change the values and attitudes of society towards children and adolescents with serious emotional, behavioral, or mental disorders.

- Families and professionals must dare to not accept perceived limits and actual barriers that are placed on children and adolescents with serious emotional, behavioral, or mental disorders.

- Families and professionals must be willing to dream and take risks that will improve the quality of opportunities available to children and adolescents with serious emotional, behavioral, or mental disorders.

- Without dreaming and risk-taking, full citizenship for children and adolescents with serious, emotional, or mental disorders will not be achieved.

March 1990

Chairwoman SCHROEDER. Thank you very much, and we really appreciate your testimony.

Dr. Behar.

STATEMENT OF LENORE B. BEHAR, PH.D., SPECIAL ASSISTANT FOR CHILD AND FAMILY SERVICES, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, DIVISION OF MENTAL HEALTH, DEVELOPMENT DISABILITIES AND SUBSTANCE ABUSE, OFFICE OF CHILD AND FAMILY SERVICES, RALEIGH, NC

Dr. BEHAR. Thank you very much.

I am going to speak briefly about two demonstration projects, primarily the project at Fort Bragg, to exemplify for you the kinds of community-based services that we all have been talking about.

Within the State of North Carolina for the past 20 years, we have been working to develop a state-wide system of community mental health services for children with serious emotional problems, and one approach that we have used is the development of demonstration projects.

It was very fortunate, I believe, that several years ago we joined forces with some of the mental health professionals at Fort Bragg, at the Army installation, because they were concerned about the mental health of children on the Army post. From that original planning meeting grew the first and only comprehensive mental health demonstration project in the country, and I think it is to the Department of the Army's credit that they were willing to forge new ground and to fund a project that I hope will provide guidance and leadership not only for the State of North Carolina, but for all of the rest of us.

General Ledford, the Surgeon General of the Army, visited the project a few weeks ago and was quite impressed with what he saw, and I will say again that we are quite impressed with him and his staff.

Between 1986 and 1989, the CHAMPUS costs for psychiatric hospitalization and residential treatment of military children rose 154 percent. I believe that if the other payers for psychiatric hospital and residential treatment would separate the child and the adult figures, they would find similar increases. The CHAMPUS data system at this point is in many ways more sophisticated than some of the other systems, and what they have seen is a tremendous rise in the use of hospitalization for emotionally disturbed children.

So what the project that we have in place is to do is not only to demonstrate the effective mental health treatment and clinical outcomes with children, but to serve as a cost containment measure, as well.

I am going to ask those of you who have the handout that I have prepared in front of you to turn to the seventh page, and we can go through the pictures, which are worth thousands of words, I hope, and not take quite as long to describe this project. If you will go to the section that says "Project Plan," as such, and then start on the next page, I will describe for you that the project has three major parts.

The administration is by the State of North Carolina, the Division of Mental Health and Developmental Disabilities and Substance Abuse Services in my office, and there are two subcontracts, one for clinical services at the General James Rumbaugh Clinic and the other for program evaluation, which is being conducted by Vanderbilt University.

The project began in August of 1989, and is scheduled to continue for 57 months. The clinical services were phased in over an 11-month period and began June 1, 1990.

I should mention that the population of children that are being served in this area is 40,600 children. Those are the military children that are in the Fort Bragg catchment area.

The benefit of the demonstration program is that the child remains at home to the extent possible. Family life is not disrupted. There will be a lower cost per child served. More children will be served. All of the local providers are being used. There are more service options available, and the services are systematized and efficient.

If you will go to the next page, you will see a chart that depicts what traditional CHAMPUS services are, which traditional CHAMPUS will pay for, which is very similar to other third parties, other insurance companies, except that most of them do not pay for residential treatment, but only hospitalization.

What you will see from this chart is that in the absence of what I call a mid-range of services, children who need more intensive services than individual counseling, out-patient treatment or family treatment, must go to the hospital. There is nothing in between.

Mr. **Miller**. Excuse me. Nothing reimbursable are you saying?

Dr. **Behar**. There is nothing reimbursable. In fact, and this is a point that I want to get to, that when we are looking at programs like IV(e), Medicaid, CHAMPUS, we are talking about reimbursement programs, and in the absence of money to start those programs, they do not exist.

They may exist in small amounts with state monies, but that is, I think, an issue that we have to look at; that what is reimbursable basically is what exists because there is nobody to even start the other services.

But your point, of course, is accurate, that in the absence of other forms of funding, reimbursement drives the system.

So in the absence of those services, the third parties are paying for more expensive services, and the children are being separated from their families. This project is a "central point of entry" project. All children who are CHAMPUS eligible must come through this project, which allows something that is lacking in the rest of the service system in most of the country, which is a comprehensive, diagnostic assessment to understand what it is that the children need, what their strengths are, what their weaknesses are, what the family strengths are and what the family needs help with.

The next page reflects the entry into the system, and I will mention that there is an emergency service as well as a non-emergency service. It is interesting to me that with 50 emergency cases on average per month, only two of those are hospitalized on average if intensive crisis services are provided. That is not the general rule across the country.

This project also has a seven to ten-day waiting period for non-emergencies and immediate service for emergency needs, and I think you will hear particularly from the family members that that also is something that is very difficult to come by, which is immediate service for an emergency and only a seven to ten-day delay for non-emergencies.

Moving on ahead, I will point out to you we have been talking a little bit about costs, and if you look at this chart, you will see that the cost of this system that has been put into place is substantially less than a traditional reimbursement system, and one of the figures that has not been bandied about just yet, but I will bring it up, is the $641 a day hospital charge, plus $80 for physician fees, for $721 a day. That is the CHAMPUS approved rate for high volume providers.

And that is not to say that the service is not worth it. It is to say that if you do not need it, why spend it?

Now, I would like to tell you a little bit about what has happened to this project, knowing as you do that we have had a war in the last few months. There has been a very interesting impact on the mental health service system, and I refer you to this chart, which is several pages ahead, and you can see quite graphically that the increase in requests for services was tied to four major periods. One was when the clinic opened. The second was when the troops were deployed. The third was when, and this one took a while to figure out, when there was announcement that there will be no rotation of troops, which meant that the soldiers were not coming home, and then when the war was declared.

I will also point out to you that the military communities and the civilian communities, as well, have done a spectacular job in providing support for children and families under stress. The services that were provided at the Fort Bragg project were not for children who were merely under stress, if one can say "merely under stress." These were children with serious, diagnosable mental health problems that were exacerbated by the war situation. It is a very different cup of tea than the support services that were provided in the schools.

Now, there are two more points that I would like to make. One is that even with a war, in this program, which has no deductible, no co-payment, is basically a free service, is open to anybody who feels that they need help, the utilization of these services will serve less than six percent of the population of children over the year. That is fairly similar to what was found in the Ontario child study, that even with an identifiable need through the epidemiology studies that Congresswoman Schroeder mentioned earlier, one in five, up to 20 percent of the children need services, and we see only five to six percent seeking service.

In the state systems we are seeing far less. We are seeing two to three percent of the population.

The last point I want to make about the Fort Bragg project is this chart, which I think is fairly spectacular and would, I hope, warm the hearts of everybody as they leave here today because what we have demonstrated here is the declining use of hospital services as the community-based systems have opened, even with a dramatic increase in the number served.

The percentage of in-patient use has gone down to under two percent, even with a large number of children coming in. The community services opened in November, December and January, and I think you see from looking at this that the use of community systems really does make a difference.

I should mention for those of you who do not have this chart in front of you the community system involves all types of in-home crisis stabilization services, emergency services, a lot of day treatment programs, a lot of programs in the schools to keep the children there that are done by mental health providers and some therapeutic home programs and group homes, and then the purchase of hospital services.

I am only going to very briefly mention the Robert Wood Johnson project which is just beginning in the western part of North Carolina. It is another demonstration program. We are one of eight states with such a program, and ours is in the Appalachian region, a rural part of North Carolina. Of course, you know it is a very poor area. It is also tri-racial. The largest population is white, but seven percent are American Indians, Native Americans, and 3%, a black population.

The goal there is to focus on alternatives to out-of-home placements. One major impact at this point of that project, which is brand new, is the restructure of the financing of mental health services within the State of North Carolina. We have restructured two reimbursement programs, entitlement programs. One is IV(e), and you have heard a bit about IV(e), and the other is Medicaid.

The reimbursement now is expected to increase by $15 million a year, not by what Congressman Miller suggested before which was, I think, a misuse of administrative funds, but in fact, the state was never using IV(e) appropriately. Now with restructuring and using those funds in ways, which were very narrow, we will see a $15 million a year increase in revenue.

The second restructuring has been in Medicaid, and we expect a 300 percent increase in Medicaid, with an expected reimbursement for children's mental health to reach $19 million.

And lest anybody think that we have solved all of our mental health problems with that kind of restructuring, I would point out to you again what I said about reimbursement, which is that it only pays after the fact for services that do exist, plus the fact that Medicaid, particularly in the southern states, addresses only a small part of the population in need.

Thank you.

[Prepared statement of Lenore B. Behar, Ph.D., follows:]

PREPARED STATEMENT OF LENORE B. BEHAR, PH.D., SPECIAL ASSISTANT FOR CHILD AND FAMILY SERVICES, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES DIVISION OF MENTAL HEALTH, DEVELOPMENT DISABILITIES AND SUBSTANCE ABUSE, OFFICE OF CHILD AND FAMILY SERVICES, RALEIGH, NC

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Close to Home: Community-Based Mental Health for Children

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CLOSE TO HOME: COMMUNITY-BASED MENTAL HEALTH FOR CHILDREN

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I. Introduction

During the past 20 years, efforts within the State of North Carolina have focused on the development and delivery of community-based services for children with mental health problems. North Carolina was one of the first states to establish a state office for child mental health and to develop a focus on this population by the community mental health centers across the State. Efforts to develop a full range of community-based mental health services have been piecemeal and painfully slow, with the exception of the services developed in response to litigation, beginning in 1979, which provided a full continuum of community-based treatment services across the State for approximately 1200 seriously disturbed, assaultive children.

In 1987, the North Carolina General Assembly adopted a Child Mental Health Plan providing a blueprint for the development of a complete system of mental health services; this plan was incorporated into the state plan required by P.L.99-660. Given the adoption of a comprehensive, community-based plan in principle, it became essential that the effectiveness of this model be demonstrated and thus provide an impetus for a statewide system of child mental health services to be built on the foundation existing through the community mental health programs.

II. North Carolina's Demonstration Projects

In addition to the basic, public mental health services to approximately 25,000 children, there are four major demonstration projects in North Carolina addressing the mental health problems of (1) infants, toddlers and preschoolers, (2) hospitalized youth, (3) military children, and (4) seriously disturbed children in rural areas at risk of out-of-home placement. It is the latter two programs on which I will focus today.

The Child and Adolescent Mental Health Demonstration Project at Fort Bragg

In August, 1989, through a five year contract with the Department of the Army, the Division of Mental Health, Developmental Disabilities began the most comprehensive continuum of child mental health services in the country. The Surgeon General of the Army, General Ledford, and his staff in Washington, those at Health Services Command and at Fort Bragg are to be praised for their willingness to fully support such an extensive demonstration project. The goal of this project is to provide the full continuum of child mental health services in order to deliver the most appropriate, cost effective services, with

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particular emphasis on providing alternatives to inpatient and residential treatment those in need, of the 41,600 children of military families in the Fort Bragg catchment area. Given the dramatic increase of 154% in CHAMPUS hospital and residential treatment costs for children and adolescents during the FY86 to FY89 period, this demonstration was designed not only to study the effectiveness of the continuum of care on treatment outcomes but to serve as an major effort at cost containment of CHAMPUS costs.

The graphics in Attachment 1 provide a pictorial description of the project plan and current status of the project. As we move through these graphic presentations, I will further describe the project.

A detailed description of the clinical services of the project is provided as Attachment 2.

As you can see, the impact of the deployment and of Desert Storm on the utilization of services has been substantial, leading to the speculation that without the availability of services, the longer term impact on the emotional adjustment of the children might have been more severe. Fortunately, this speculation can be studied through the comprehensive evaluation that is also a part of this project. In addition to providing for the delivery of the full continuum of treatment services, the Department of the Army is to be further commended for funding a thorough evaluation of the project. The funding by the Department of the Army has been augmented by funds from NIMH to expand the evaluation activities. The project evaluation, which is being conducted by Dr. Leonard Bickman at Vanderbilt University, addresses the costs of the services, the quality of the services, and the impact of the services on the mental health problems of the children. The services provided at Fort Bragg are being compared to those at two control sites, Fort Campbell and Fort Stewart.

The Robert Wood Johnson Child Mental Health Demonstration Project

In 1989, North Carolina was one of twelve states to receive a Planning Grant from the Robert Wood Johnson Foundation to develop the structure for a comprehensive system of services for seriously disturbed children. In 1990, North Carolina was one of eight states to receive an Implementation Grant to put into place a comprehensive system of services using an interagency collaboration case management model. This Implementation Grant, lasting four years, will total two million dollars of foundation funds plus two million dollars of state matching funds for new mental health services for children and adolescents.

The target population selected by the state includes seriously emotionally disturbed (SED) children who have been removed from their homes or are at imminent risk of removal from their homes. A diagnosis of emotional disturbance and a functional impairment score greater than 40 on the North Carolina Functional Assessment Scale are other criteria delineating the target population.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services serves as lead agency at the state and local levels, with the responsibility of coordinating the other child-serving agencies. The actual demonstration sites for the project are the eleven most western counties of the state. These counties are contained in the Blue Ridge Area Mental Health Program and the Smoky Mountain Area Mental Health Program and are served by over 60 public agencies. The area has a long history of cooperation among agencies, perhaps the best in the State, and is characterized by creative programming in the face of limited resources, mountainous terrain, and a significant poverty level. It is a multi-racial area whose population is divided as follows: white (86%), Native American (7%), African American (6%) and other (1%).

There has been growing awareness in the state that the current methods of planning, financing and delivering services to SED children need improvement. Statewide problems include 1) insufficient resources; 2) fragmentation of service systems; 3) uncoordinated program management; and 4) insufficient input from parents. The Child Mental Health Plan, adopted by the Legislature and by the Administration in 1987, has provided guidance on these issues; but implementation has been insufficient to determine the strengths and weaknesses of the Plan. The North Carolina Mental Health Services Program for Youth (the N.C. RWJ Project) offers the opportunity to address these issues through an interagency forum at both the state and local levels resulting in a state-local partnership to improve the system.

The major goals of the North Carolina RWJ Project are: 1) to implement a full continuum of services for SED children in the demonstration sites; 2) to develop and implement new financing mechanisms for child and youth mental health services; 3) to establish a model of interagency collaboration and case management that can be disseminated across the state; and 4) to reduce out-of-home placements and psychiatric hospitalizations for the target population and to demonstrate that the continuum of community-based services is a less expensive, equally effective option to hospital-based services. Objectives for the first two years address the expansion and reorganization of services for the target population. In the last two years, objectives focus on full implementation of new financing mechanisms, the use of a single unit cost-finding system across agencies and methods of disseminating the model for replication.

Activities in the Planning Year focused on establishing interagency forums of child serving agencies at the state, area and county levels to define processes which would be the core of the management system. County interagency agreements were developed and signed, addressing roles and responsibilities in the referral, diagnosis and treatment process; criteria for the target population and mechanisms for prioritizing clients in need of services; a method of implementation of a client tracking system and development of a data base. The Project Management Team, an interagency planning group at the area and regional level, produced a mechanism for Quality Assurance, including

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utilization review and peer review done by representatives of multiple agencies. The Project Management Team defined its functions to include problem solving at the regional level and the mechanism for referring issues from the local sites to the state level Oversight Committee.

At the state level, an interagency Oversight Committee gave support to local activities and provided a statewide perspective on proposed changes in the service system. A state level Interagency Agreement was written and signed in the fall of 1990 by the Secretaries of the Departments serving children and families. Staff in the Child and Family Services Branch of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) provided support to the Oversight Committee and reviewed financing mechanisms to determine improved methods of using available funds, particularly federal entitlement programs Medicaid and Title IV-E. Thus far, major strides have been made, with substantial collaboration with the Division of Social Services, in planning for the restructuring of Title IV-E procedures to increase revenue. It is anticipated that $15 million of new revenue per year will result from the restructuring of Title IV-E procedures; of this amount, 20% will be for Mental Health, Developmental Disabilities and Substance Abuse Programs and 80% will be for Social Services Programs. Major changes have occurred in the Medicaid program to broaden covered services and increase reimbursement rates with an expected increase of 300% in Child Mental Health revenues to $19 million.

Based on input from the state and local agencies, the emphasis of the service system will be on non-residential services designed to keep children in their homes. Removal from home, when needed, will be for the shortest time possible, primarily for crisis stabilization. The service components will be expansions of existing services which do not exist in sufficient quantities or currently are designated for Willie M. clients only. An important focus will be on thorough assessment of the child and family strengths and needs as the basis for the intervention plan. The assessment and treatment planning will be completed jointly by the agencies involved or to be involved with the child in child-specific intervention teams. A case manager will oversee service delivery and maintain involvement of the agencies.

The role of parents will be strengthened through the development of a consumer-advocate advisory group at the local level and through representation on the Oversight Committee.

A training plan has been developed to orient new staff, provide continuing education to existing staff, and to focus on interagency collaboration and case management. Training events that include staff from other child-serving agencies and consumers will be regularly scheduled.

Dissemination of successful treatment models and management systems will be accomplished through statewide conferences and local training. Small work groups will be used to provide

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information on cost effectiveness and financing mechanisms to decision makers who determine the allocation of state and federal funds and to third party payors like insurance companies, self-insured employers and designers of benefit packages. A long-range goal is to propose a system for insurers to expand covered services to include alternatives to hospitalization for SED children and youth.

The National Institute of Mental Health has awarded a research grant to the State, the University of North Carolina at Chapel Hill, and Duke University to study the effectiveness of case management services in the mental health system of care developed in two of the eleven counties in this demonstration project. Two models of case management will be compared. The project also includes an analysis of cost-effectiveness of services and study of service coordination patterns in interagency councils.

The long range impact of this project could be substantial. If the goals are successfully met, the increased funding of the Child Mental Health Plan could be accelerated. The lessons learned from this rural site could be useful both statewide and nationally.

ATTACHMENT 1

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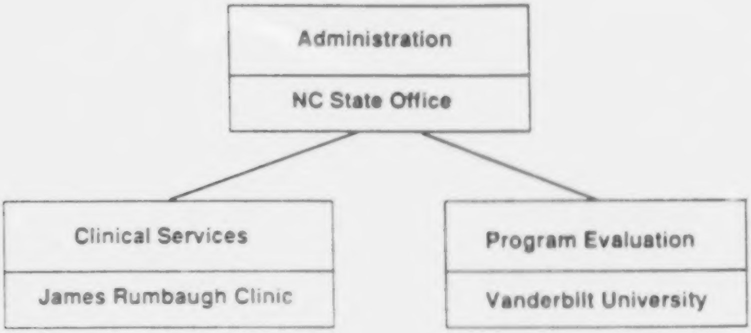
PROJECT PLAN

THE PROJECT HAS THREE MAJOR PARTS


Administration
NC State Office
Clinical Services
James Rumbaugh Clinic
Program Evaluation
Vanderbilt University

The Project began in August, 1989 and is scheduled to continue for 57 months until May, 1994.

Clinical services opened on June 1, 1990 as scheduled, after an 11 month mobilization phase.

Benefits of the Demonstration Project Child Mental Health

- ✚ child remains in the home
- ✚ family is not disrupted
- ✚ lower cost per child served
- ✚ more children served
- ✚ local providers are used
- ✚ more service options available
- ✚ services are systematized and efficient

↓

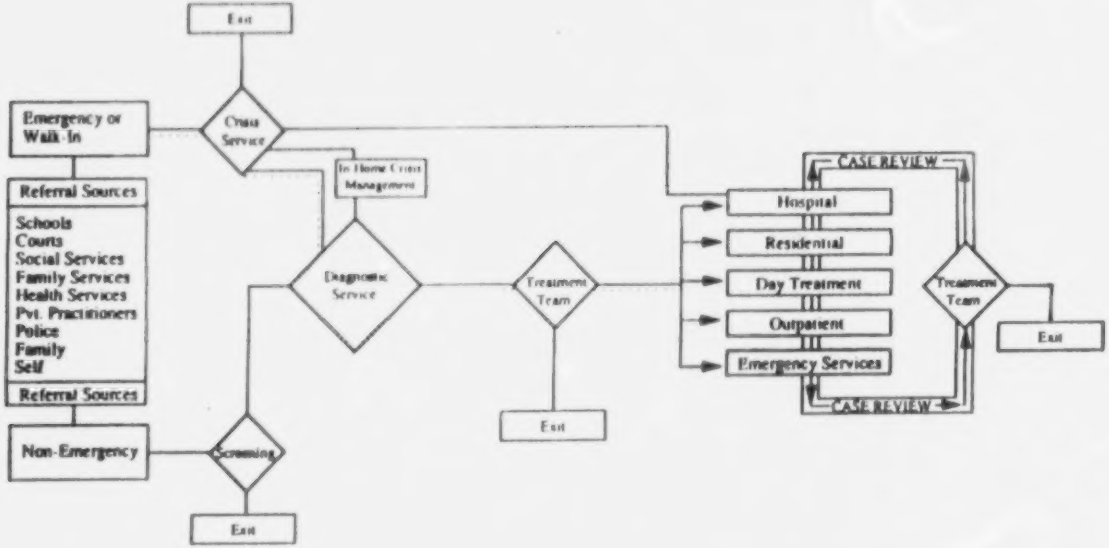
Better and more services tailored to clients' needs.

Services	Traditional CHAMPUS	Demo Services
Hospitalization	●	●
Residential Treatment		
Large Setting	●	●
Group Home		●
Professional Parenting, Specialized Foster Care		●
Supervised Independent Living		●
Day Treatment		
High Management - full-day		●
Moderate Management - full-day		●
Moderate Management with public school-half-day		●
Therapeutic Vocational Placement		●
Therapeutic Preschool (ages 0 - 6)		●
Evening Treatment		
After School or Work - half-day equivalent		●
Therapeutic Camping		
Weekend, Summer, or Year Round		●
Outpatient		
Individual Treatment (office or home)	●	●
Family Treatment (office or home)	●	●
In-School Support Services		●
Emergency Services (available 24 hrs./day)	●	●
Family Preservation		
In-Home Crisis Stabilization	●	●

The goal of the program is to develop a wider range of services than traditionally funded by CHAMPUS and thus provide alternatives to hospital and residential services.

Service Characteristics

Traditional CHAMPUS	**Demonstration Services** *In addition to a wider range of services, the project provides*
• Not a case management system	• Individualized, ongoing case management system.
• Services may or may not be under one administration.	• Services are all under one administration.
• If not under one administration, family must locate next level of service.	• Movement across services is determined by a Treatment Team in collaboration with the child, the family, and other professionals.
• If not under one administration, family must apply for admission.	• Central point of entry into the system.
• No central point of entry into the system.	• Required comprehensive assessment prior to treatment
• No requirement for a comprehensive diagnostic assessment prior to treatment.	


Exit
Emergency or Walk-In
Crisis Service
In Home Crisis Management
Referral Sources
Schools
Courts
Social Services
Family Services
Health Services
Pvt. Practitioners
Police
Family
Self
Referral Sources
Non-Emergency
Screening
Exit
Diagnostic Service
Treatment Team
Exit
CASE REVIEW
Hospital
Residential
Day Treatment
Outpatient
Emergency Services
CASE REVIEW
Treatment Team
Exit

Children enter the system either as emergencies or non-emergencies
They all receive comprehensive diagnostic service which is overseen by a treatment team
Once the child enters treatment, progress is reviewed every 30-45 days
The family participates in the entire process

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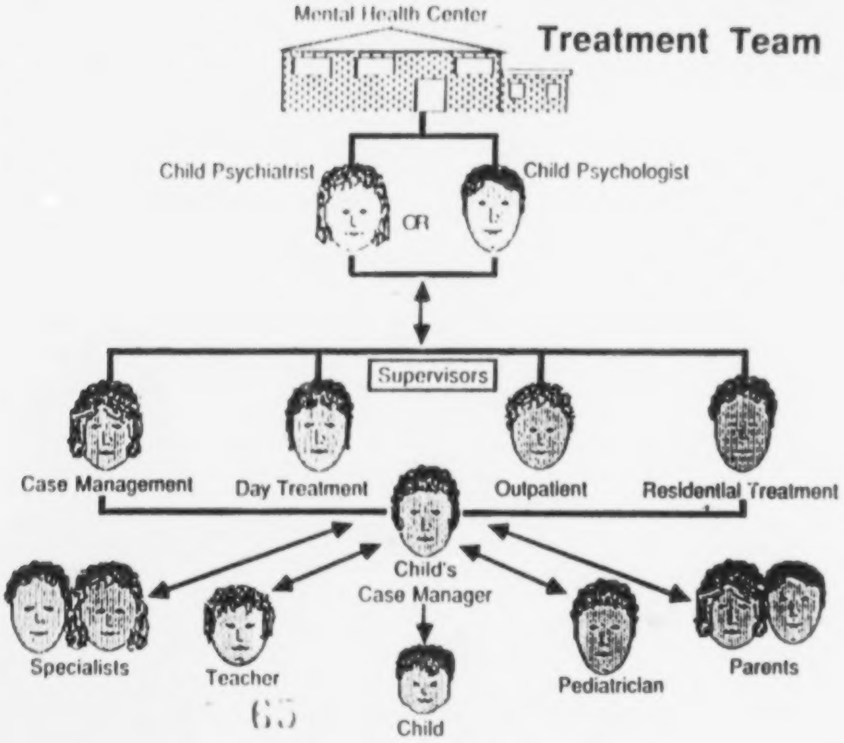
Treatment Team


Mental Health Center
Child Psychiatrist
OR
Child Psychologist
Supervisors
Case Management
Day Treatment
Outpatient
Residential Treatment
Child's Case Manager
Specialists
Teacher
Child
Pediatrician
Parents

An Example Comparing Services of the Project to Traditional CHAMPUS

Demonstration Services

				TOTALS
Services	In Home Crisis Stabilization	Living at Home Day Treatment Outpatient for Child and Family Case Management	Outpatient for Child and Family Case Management	
# of Days	30 days	213 days	183 days	= 426 days
Cost	$4,950	$27,384	$4,656	= $36,990

Total Service Costs	$36,990
Support Services	$ 2,000
	$38,990

Average cost per day = $91.53

Traditional CHAMPUS

				TOTALS
Services	Hospital	Residential Treatment	Living at Home + Outpatient for Child and Family	
# of Days	60 days	183 days	183 days	= 426 days
Cost	$43,260	$75,030	$3,600	= $121,890

Average cost per day = $286.13

The preceding chart was determined using these figures.

DEMONSTRATION SERVICES

Services	Unit Cost x # of Units	Total Unit Cost	Total
In-Home Crisis Stabilization	$165.00 x 30 days	$4,950.00	$4,950.00
Day Treatment	$126.00 x 130 days (5 x week)	$20,160.00	
Outpatient (child/family)	$65.00 x 48 hours (2 x week)	$3,640.00	
Case Management	$64.00 x 48 hours (2 x week)	$3584.00	$27,384.00
Outpatient (child/family)	$65.00 x 48 hours (2 x week)	$3,120.00	
Case Management	$64.00 x 24 hours (1 x week)	$1,536.00	$4,656.00
			36 990.00
Support Services			
-Emergency Services			
-After School Services	$2,000.00 (estimated cost)	$2,000.00	$2,000.00
-Weekend Therapeutic Camping	provided as needed		
-Respite			
			$38,990.00

TRADITIONAL CHAMPUS

Services	Unit Cost x # of Units	Total Unit Cost	Total
Hospital			
-Room	$641.00 x 60 days	$38,460.00	
-Physician	$80.00 x 60 days	$4,800.00	$43,620.00
Residential Treatment			
-Room	$350.00 x 183 days	$45,750.00	
-Physician	$60.00 x 183 days	$10,980.00	$75,030.00
Outpatient (child/family)	$75.00 x 48 hours (2 x week)	$3,552.00	$3,600.00
			$121,890.00

STATUS REPORT

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- When the General James Rumbaugh Clinic opened on June 1, 1990, there were almost three times the number of children transitioning into the program as CHAMPUS data had predicted, that is, 284 clients rather than 100.

- Through rapidly increasing the internal staff and increasing the number of private providers under contract, children and their families were served quickly by the end of July.

- However, by September, the active caseload quickly doubled to 740 following the deployment of troops from Fort Bragg.

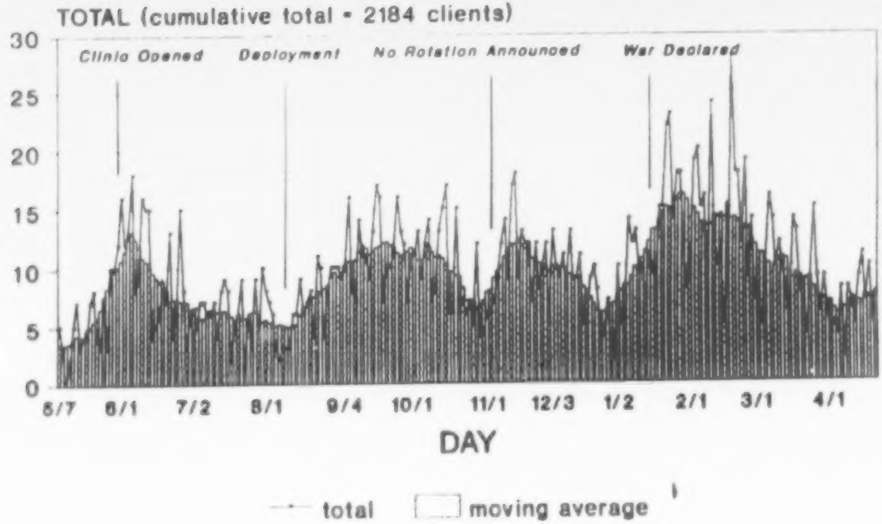
- And in November, there was another rapid increase to 1078 children following the announcement that there would be no rotation of troops.

- By February, the number of children receiving treatment increased to over 1200 following the start of war.

- Staffing of the clinical services has kept up with the demand. By February, all components of the system were operational in keeping with projected time lines.

Scheduled Intake Assessments

May, 1990 - April, 1991

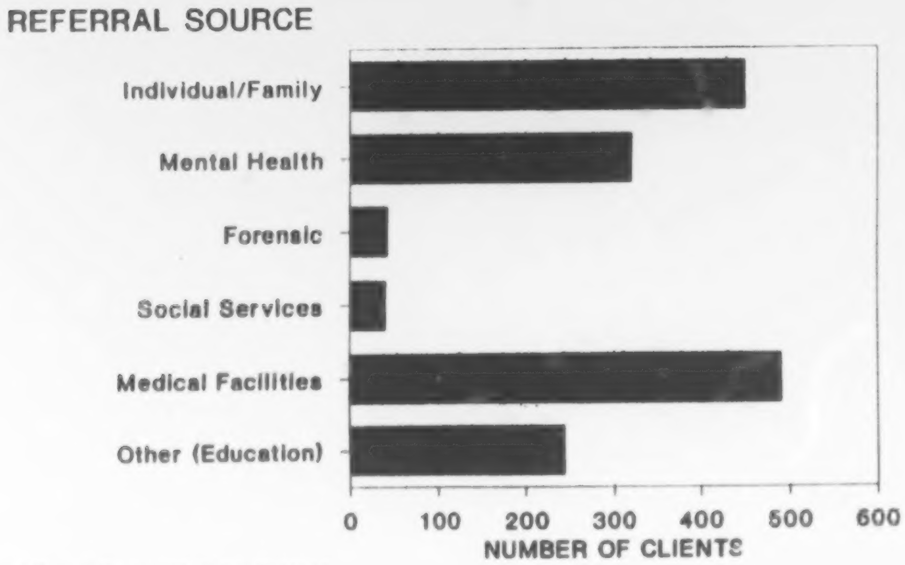


Fort Bragg Demonstration Project

Clients have been referred by the traditional sources. However, beginning in September, referrals from WOMACK Army Community Hospital increased substantially. These referrals have been from Pediatrics primarily. These increased referrals were most likely because the pediatricians had been deployed and the reservists could not predict long-term continuity of care for the children.

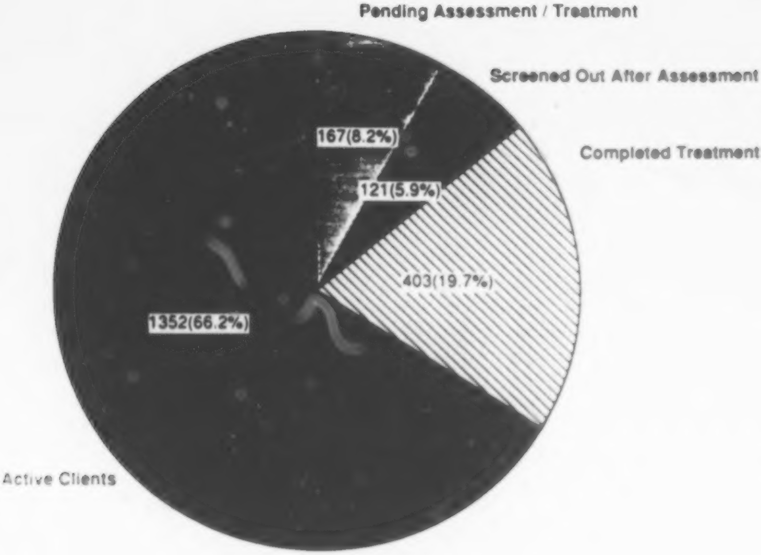
CLIENTS BY REFERRAL SOURCE

6/1/90 - 2/12/91



Fort Bragg Demonstration Project

Status Report of the Number of Clients Accessing the Treatment System

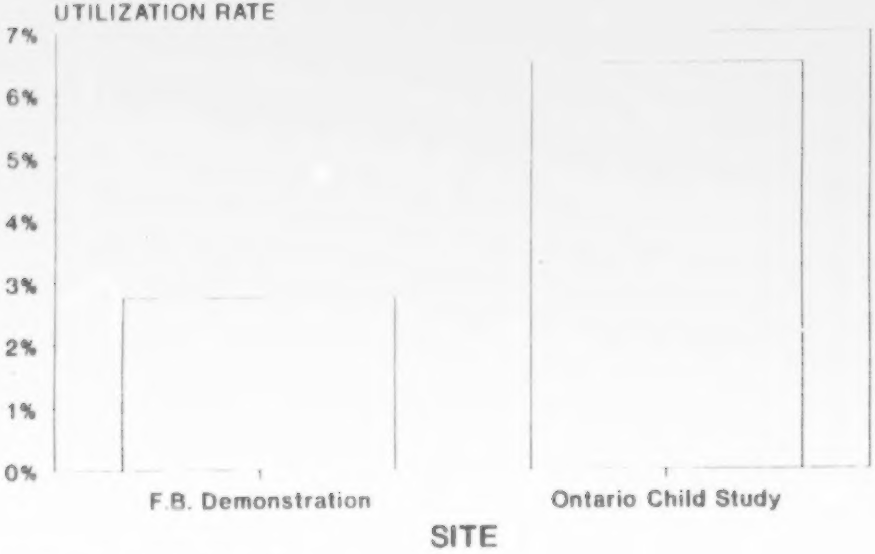


- Total number of children receiving services = 2,043 (6/1/90 - 4/12/91), 10. 5 months
- Population of children in the Fort Bragg catchment area under age 18 = 41,600
- 4.9 % of child population has entered the system

- Approximately 15% (360) of those requesting services (2,403) were screened out prior to admission

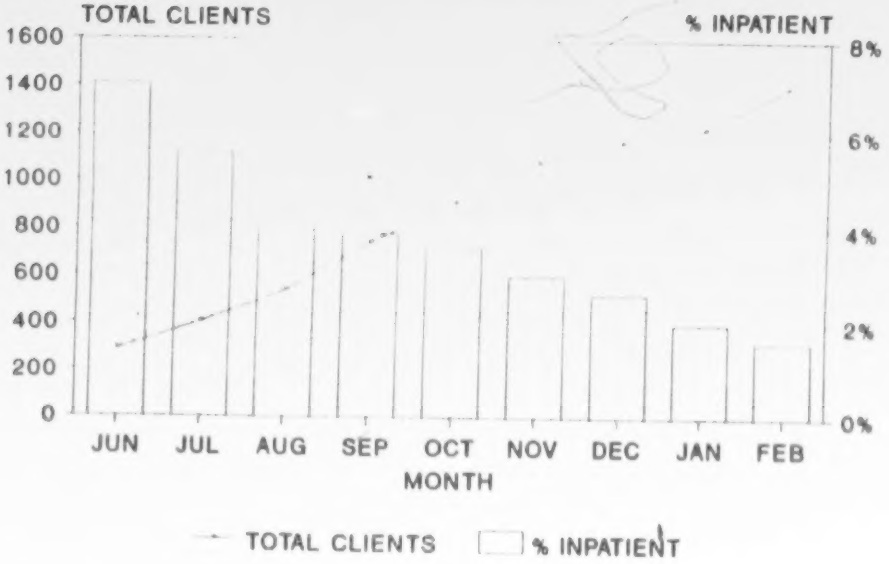
6-MONTH UTILIZATION RATES

Demonstration Vs. Literature



Fort Bragg Demonstration Project

INPATIENT (HOSPITAL AND RTC) UTILIZATION AS A PERCENTAGE OF TOTAL CLIENTS



Fort Bragg Demonstration Project

FORT BRAGG DEMONSTRATION PROJECT

INPATIENT (HOSPITAL AND RTC) UTILIZATION AS A PERCENTAGE OF TOTAL CLIENTS

MONTH	TOTAL CLIENTS	AVERAGE HOSPITAL BEDS/DAY	% OF TOTAL CLIENTS	AVERAGE RTC BEDS/DAY	% OF TOTAL CLIENTS	TOTAL INPATIENT BEDS/DAY	% OF TOTAL CLIENTS
06/90	284	10.9	3.8	9.1	3.2	20.0	7.0
07/90	403	12.4	3.1	10.0	2.5	22.4	5.6
08/90	537	11.6	2.2	9.6	1.8	21.2	3.9
09/90	740	15.3	2.1	13.3	1.8	28.6	3.9
10/90	909	17.0	1.9	15.4	1.7	32.4	3.6
11/90	1078	18.1	1.7	14.2	1.3	32.3	3.0
12/90	1166	12.5	1.1	18.0	1.5	30.5	2.6
01/91	1226	10.7	0.9	13.7	1.1	24.4	2.0
02/91	1404	15.3	1.1	6.8	0.5	22.1	1.6

ATTACHMENT 2

Fort Bragg Demonstration Project :

Implementation of the Continuum of Care

Fort Bragg Demonstration Project :

Implementation of the Continuum of Care

Client Population

Clients served by the Rumbaugh Clinic are drawn from a population base of over 41,600 CHAMPUS-eligible children and adolescents under the age of eighteen who reside in the Fort Bragg catchment area. Clients must meet criteria for a mental disorder as defined by DSM-III-R other than, or in addition to, V-code conditions, mental retardation, or specific developmental disorders.

Clinical Programs

Prior to the initiation of services by the Rumbaugh Clinic on June 1, 1990, the planned levels of care were (1) Outpatient Services, (2) In-Home Services, (3) Community Education/Treatment Services, (4) Residential Services (to include therapeutic homes and therapeutic group homes), and (5) Inpatient Services. Intake Assessment/Emergency Services were developed as a discrete section with the primary functions of determining eligibility for services, initiating the treatment planning process and coordinating 24-hour emergency coverage. It is an essential component of the system of care which does not represent a level of care. Psychiatric and Substance Abuse Services have been designed to provide consultation and support to all other sections, across all levels of care. In addition, Clinical Case

Management was established as a separate section with the objective of providing "operational services" (Stroul & Friedman, 1986) within the system of care. The purpose of the following is to describe more fully the functions, current staffing, and current utilization rates of the above-mentioned services.

Intake Assessment/Emergency Services

Intake Assessment provides the point of entry into the system of care for all clients. A comprehensive diagnostic protocol is completed which includes child and parent clinical interviews (Dougherty & Schinke, 1989a; Dougherty & Schinke, 1989b), developmental history (Rainwater & Slade, 1988), social and family history which covers educational/legal/medical domains, standardized behavioral checklists from multiple reporters (Achenbach,1987; Achenbach & Edelbrock, 1983a; Achenbach & Edelbrock, 1983b), substance abuse screening for ages eleven and older (Winters & Henley, 1989), and measurement of stressful life events (Johnson & McCutcheon, 1980). In January, 1991, this section achieved the goal of scheduling non-emergency intake assessments within one week of the initial telephone screenings. Emergency assessments are available within two hours of telephone contact on an around-the-clock basis. Emergency assessments are clearly tied to crisis intervention services, which are either directly provided or coordinated by this section, with full-time administrative, psychological and psychiatric support.

At present, this section is led by a Master's-level psychiatric nurse. There are also five Master's-level staff clinicians and two staff psychiatric nurses in this section.

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Contractors have been utilized on a part-time basis to help manage the demand. Since the clinic started scheduling intake assessments in May, 1990, over 2,000 intake assessments have been performed.

Treatment Planning Process. Intake assessment data is presented to a multidisciplinary treatment team, led either by a licensed psychologist or a child/adolescent psychiatrist, within two days of the intake interview. At that time, the treatment team makes decisions regarding eligibility for services, diagnoses, preliminary treatment plan, and disposition, including level(s) of care determination. If a client is referred to "outpatient-only" services, a comprehensive treatment plan must be developed within 30 days of admission, at which time the plan is reviewed by the multidisciplinary team. Subsequently, outpatient-only treatment plan reviews by the treatment team must occur at least every 12 sessions or 6 months, whichever comes first. Any member of the team may call a team meeting at any time, however, in order to address problems or review proposed changes in the treatment plan. Clients who are referred to any services other than outpatient-only at the initial treatment team meeting must have a comprehensive treatment plan and team meeting within two weeks of admission. Treatment team meetings and treatment plan reviews for these clients must then occur at least every 45 days; again, as with all cases, any team member may call a meeting at any time in order to address concerns or modify the treatment plan. Any changes in level of care require prior review at a treatment team meeting.

Outpatient Services

Outpatient services in this system of care are provided by contract providers in the community (about 90% of cases) and by Rumbaugh Clinic staff. Outpatient services within the clinic have been more broadly based and flexible than traditional private practice, with emphasis on family-based treatment, group treatment, and ecologically valid assessments and interventions which require clinicians to work out of the office setting. A wide range of intensity and frequency of services is available, as are specialized evaluations. In order to sustain clients with greater problem severity at the outpatient level of care, for example, clinicians have been authorized to see clients up to five times weekly during periods of crisis. Outpatient clinicians may also provide treatment in conjunction with other services in the system of care. Evening hours have been established to improve accessibility. Treatment is expected to focus on supporting and enhancing adaptive competencies within the client and family, utilizing empirically supported interventions when at all possible, while maintaining a standard that all treatment must be individualized.

Rumbaugh Clinic Outpatient Services is led by a senior child psychologist. Section staff includes three Doctoral-level psychologists, one Master's-level psychologist, one Master's-level psychiatric nurse, one Master's-level clinical social worker, and two Master's-level clinical substance abuse counselors. We are currently interviewing applicants for child psychologist and clinical social worker positions. These staff are currently providing treatment to over 147 clients.

In-Home Services

In-Home services represent an intermediate level of care that has not previously been available to this client population. Generally, this section is modeled on "family preservation" programs (Edna McConnell Clark Foundation, 1985). The primary purpose is to prevent out-of-home placement of children from families experiencing acute crisis, for whom outpatient services are inadequate. In-home treatment may also be used as stepped-down service from residential/hospital care to promote successful reunifications of families. Therapists are each assigned caseloads of two to four families, and are essentially on call for those cases around the clock. Interventions are typically provided in the client's home. Methods utilized include skills training, systemic family therapy, supportive counseling, and helping the family access other needed services or resources. The length of treatment is usually between 6 and eight weeks.

This section is led by a Master's-level clinician with training in psychology and social work. There are currently four Master's-level clinicians on staff and we are recruiting for 6 additional Master's-level positions. These positions have been relatively difficult to fill, but our most recent recruiting efforts are encouraging. Since Rumbaugh Clinic opened June 1, 1990, the In-Home section has worked with 49 cases, including 7 current cases. We are beginning to examine outcomes of treatment for this, as well as other, sections; in terms of preventing residential or hospital placements. The preliminary findings are promising.

Community Education Treatment Services

Community Education Treatment Services (CETS) provides essentially two program levels: after-school and day treatment. After-school services may be provided when clients are at high risk for day treatment, residential or inpatient services. This program provides a highly structured, diverse treatment package from three to five afternoons per week for about three hours per session. When clients are displaying behavioral/emotional problems in the school setting of such intensity that continuation at the home school is presently impossible or they are at high risk for residential or inpatient treatment, then the day treatment program may be appropriate. Clients may access both programs as stepped-down services from residential/hospital care in order to facilitate successful transitions to community, school and family. Both programs include intensive substance abuse treatment, utilized as indicated. The day treatment program is certified as a school and will emphasize enhanced academic attendance, skills, and performance. Both programs will have an environment based on social learning principles, skill development, and an understanding of the developmental tasks facing client and family. Family-oriented interventions, such as multi-family groups will also be central to these programs.

CETS is directed by a senior psychologist. Staff is currently comprised of two additional Doctoral-level psychologists, two Master's-level psychologists, three Master's-level social workers, one Master's-level substance abuse counselor, one curriculum specialist, two teachers, and four behavior programming specialists. We are currently recruiting

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for an additional Doctoral-level psychologist, one Master's-level substance abuse counselor, and two behavior programming specialists. At present, there is one site which houses the after-school and day treatment programs. We are anticipating the capacity for programming of similar size at a new site within the next few months. The existing programs in this section are tailored for adolescents; assessment of need will determine whether or not new programs will serve younger clients. The after-school program has been open since late December, and is currently serving 15 clients with 10 clients on the waiting list. The day treatment program is serving 14 clients with 1 client on the waiting list.

Residential Services

The broad view of Rumbaugh Clinic's Residential Services provides two key features: a) consistent with the treatment philosophy of the larger system, residential care will be provided with the goal of reunifying the client and family as soon as possible, and thus will integrate work with the client's family in the residential setting; b) residential treatment is seen as a more normalized, less restrictive alternative to hospital level of care, and may be utilized either to prevent the need for hospitalization or as a step down from hospital.

The Section Head for Residential Services is a clinical social worker. This person directly supervises the Therapeutic Homes Coordinator, the Group Homes Coordinator, and the Day Parent Supervisor, all being clinicians with Master's-level training at a minimum.

Therapeutic Homes. The therapeutic homes program at Rumbaugh is similar conceptually to programs such as People Places in Virginia (Bryant, 1980) and PRYDE in Pittsburgh (Hawkins, Meadowcroft, Trout, & Luster, 1985). Referrals to therapeutic homes include clients from across the eligible age span, with serious emotional/behavioral disturbances, including substance abuse disorders. Treatment planning for this component is highly flexible; for example, length of stay may range from only a few days when a home is utilized for respite to several months for more intransigent problems. Clients are generally placed singly in therapeutic homes, with occasional exceptions such as respite care situations. Therapeutic parents are licensed by the state of North Carolina, are paid a stipend as contractors with Cardinal Mental Health Group, and receive ongoing clinical support and supervision from a Master's-level social worker. There is intensive pre-service training which also serves to screen the most desirable candidates for therapeutic home contracts. This program has been able to develop relatively quickly, in large part due to a contract with the Therapeutic Foster Care Program at Cumberland County Mental Health Center, which has been successfully operating for a number of years. This contract has allowed Rumbaugh to engage in joint training and recruitment efforts with an established program.

There are currently 12 active cases receiving therapeutic home services, including respite care. There are two Master's-level clinicians on staff who will each work with 6 therapeutic home families, thus allowing intensive ongoing support.

__Therapeutic Group Homes__. The primary purpose of therapeutic group homes is to provide an intensive, highly-structured treatment program to clients with serious emotional/behavioral disturbances in an environment which closely approximates a "natural" home environment. Each of Rumbaugh Clinic's three group homes has a capacity of 6 beds. One of the homes is designed as an acute care home, with 24-hour emergency accessibility, and a 1:2 staff-to-client ratio. The other two homes are utilized on a planned referral basis and will maintain a 1:3 staff-to-client ratio. In addition to the 33 Child Care Specialists who are the line staff for the group homes, each home has a Group Home Manager with considerable experience. The Acute Care Group Home Manager is a psychiatric nurse who can provide more immediate medical intervention when necessary. There are also two Master's-level social workers who are assigned to the group homes in order to provide the individual, group and family therapies that will complete the treatment environment.

Our first group home was licensed and opened in late December, 1990. All 6 beds in that home are now utilized. The other two homes opened in February, 1991, and all of the 12 beds are now filled.

__Day Parents__. The Rumbaugh Clinic is developing a Day Parent component which will administratively fall under the Residential Services Section, while providing highly flexible, individualized support to clients in basically any setting. Thus, day parents will be utilized who are paraprofessionals with child mental health training and experience, who can implement one-on-one support and structure for clients in the home, at

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school, even to supplement staff in residential treatment. The Day Parent Supervisor, a Master's-level clinical social worker, is reviewing applicants for day parent positions.

Inpatient Services

Within the Rumbaugh Clinic system of services, inpatient hospitalization is entirely contractual. There is a private psychiatric hospital in Fayetteville, the center of the catchment area, which has both child and adolescent units and a residential treatment center (RTC). We have used this facility more than other hospital programs, primarily due to greater opportunity for sustaining family involvement as well as overall continuity of care. We also have contracts with several other hospitals in the area, which may be utilized based on family preference, special needs of the client (e.g., substance abuse treatment, eating disorders), or in emergency situations. The majority of clients admitted to inpatient services have been for short-term treatment/crisis stabilization or for comprehensive evaluations. In cases with extremely severe, chronic clinical status hospitalization has been longer-term. Although the data are preliminary, it does appear that by the end of March, 1991, the development of intermediate services described above had begun to reduce the utilization of inpatient/RTC beds in our system. After the first month of operation the percentage of active clients in in-patient facilities was 7 percent and in residential treatment centers was 3.2 percent. In March 1991 this percentage had been reduced by 1.8 percent and .15 percent respectively. As additional intermediate services come on board in the coming weeks and months, we anticipate a continued trend toward using inpatient services primarily for crisis stabilization, short-term evaluations and back-up for less restrictive services.

Substance Abuse Services

Substance Abuse Services are provided within and across all levels of care within the Rumbaugh Clinic system of care. As noted above, there are specific substance abuse clinician positions within some sections, and there are members of the clinical staff in all sections who are qualified substance abuse professionals. In order to integrate all these services, there is a Substance Abuse Services Director, who is a Master's-level clinician with experience in child mental health and substance abuse treatment. This person reports to the Medical Director of Rumbaugh, who supervises all across-section clinical services. The Substance Abuse Services Director is currently interviewing applicants for a Substance Abuse Clinical Specialist position; this person will report directly to the Director, and will assist in providing supervision, training, consultation, program development, and direct services to and within other clinical sections. Given the evidence that there is significant prevalence of problem substance use among adolescents (Braucht, 1982; National Institute on Drug Abuse, 1988), Rumbaugh Clinic is screening specifically for substance abuse (Winters, 1988) as part of the intake evaluation for all clients age 11 and older. Since opening the clinic, 71 clients have been referred for extensive, standardized substance abuse evaluations. Relapse prevention groups have been started in outpatient services and in the after-school program; this modality will be replicated in these and other levels of care. We are beginning to implement

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intensive training/supervision across levels of care in brief, family-focused treatment for substance abuse problems, so that we can continue to improve our capacity to recognize and treat problems of this type.

Psychiatric Services

Similar to Substance Abuse Services, Psychiatric Services within the Rumbaugh Clinic system of care are provided across all levels of care. There are currently three staff psychiatrists, who are trained in child/adolescent psychiatry; they report to the Medical Director, who is also a child psychiatrist. The role of psychiatry in this system includes direct services (e.g., evaluations, medication, family therapy), treatment team participation and/or leadership, program development and evaluation, and Quality Assurance functions, especially in regard to client treatment in medical facilities such as hospitals. As with Outpatient Services, many Rumbaugh clients receive psychiatric services with contract providers as well. In the first 9 months of operation, our staff psychiatrists received 257 referrals for psychiatric evaluations and were carrying about 100 cases for treatment with medication.

Clinical Case Management

The Clinical Case Management Section is headed by a Master's-level clinical social worker with substantial clinical and administrative experience. Within the section, there are two Supervisors who are also experienced persons with Master's-level credentials; one comes from the juvenile justice system, and the other from child mental health. Each of these two Supervisors has 6 Master's-level Clinical Case Managers on staff. We are

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currently interviewing and hiring at least eight Bachelor's-level Outpatient Care Coordinators, who will be distributed between the Supervisors.

In a complex system of child mental health services, it is our basic assumption that clinical case management is the key to systemic success by virtue of providing consistent advocates for the client and family who are charged with coordinating and monitoring all services throughout the course of treatment. As has been described by Behar (1985) and others (e.g., Stroul & Friedman, 1986), clinical case managers in the Rumbaugh system must also perform the broader ecological assessments of clients which may lead to linkages with supports and agencies outside the mental health system. This section is responsible for coordinating all comprehensive treatment teams, writing comprehensive treatment plans, and assuring that appropriate referrals are made and services provided. The provision of intensive case management is, of course, only relevant for cases receiving more intensive services than typical outpatient-level care. In order to provide intensive case management, caseloads in the Rumbaugh Clinic system were to be limited to 20. By March, 1991, there were over 1350 active cases in the system of care. The vast majority of these cases were being served at the outpatient level of care by contract providers. In order to manage the outpatient cases adequately, while utilising highly skilled clinical case managers appropriately for clients receiving more intensive services, we have created new positions for Outpatient Care Coordinators. These coordinators will relieve the clinical case managers of clients receiving only outpatient services, carrying caseloads of about 65 clients with correspondingly less intensive involvement. As the clinical case managers approach their target caseloads of 20, they will increasingly have a positive impact on the quality of services received by more seriously disturbed clients.

Chairwoman **Schroeder**. Thank you very much, and I know sitting on Armed Services, when they put the cap on some of the residential treatment in CHAMPUS, we heard from providers, but we did not hear much from the people who used it, which says something, too. They much prefer this new model.

Let me welcome you, Dr. Cornelius. The floor is yours, and we are glad to have you this morning.

STATEMENT OF SANDRA CORNELIUS, PH.D., PRESIDENT-ELECT, ELWYN, INC. ELWYN, PA; FORMER ADMINISTRATOR, DELAWARE COUNTY GOVERNMENT, DEPARTMENT OF HUMAN RESOURCES, MEDIA, PA

Dr. **Cornelius**. Thank you, Madam Chairman.

Chairwoman **Schroeder**. You might pull down this microphone because the acoustics are not the best in this room.

Dr. **Cornelius**. Thank you, Madam Chairman.

As fifth in your line of witnesses today, I think it would be more effective for me to serve as your yellow highlighter than to give you a full story. The authority from which I speak is that of sitting, like Mr. Kehoe, across all kinds of public money at the county level, however not the state level, public categorical funding streams that serve children and their families.

The points that I would like to highlight are as follows:

One, in previous hearings, you have heard of the prevalence and incidence of serious emotional disturbance in children. In our county of 600,000 we culled the records of all the public systems and found 2,200 individual children with very serious emotional disturbances, serious enough and of sufficient merit to have them taken out or be at risk of being taken out of their families.

The need is there. These children are not being served adequately. Our current funding streams fracture families. The children and their needy families go to where the money is rather than the services to where the families are, and in many instances we do ill-service to families that are more than interested in staying with their children, as both the first witness and the Governor testified. Families that do have emotional, psychological, familial and financial resources and the very great interest and love in caring for these children can only be served at times in our state by having them go before the judge and say, "I no longer wish custody of my children," a horrible, horrible thing.

The things that I would like to encourage beyond the testimony that has already occurred, which calls for coordination of service, centralized intake, tremendous expansion of community-based and family-based care as opposed to the balance on in-patient, are the following:

Number one, we cannot in the public sector get out of the bind that we are in now without start-up money to promote, develop and encourage the creation of a variety of community-based services that you have heard from other people. This is the very fantastic merit of the Robert Wood Johnson project in eight states. We are one of them.

This does not go to pay for direct service expansion, the direct service. What it does is it gives us money to start up new services so that we can maintain two systems for a brief period of time and then begin recapturing money out of the more expensive unit costs of institutional care.

That is an impediment, the lack of start-up money, for the significant change in any of the systems across our country.

Number two, Mr. Wolf, you talked of perhaps auditing all of these agencies. I would encourage a carrot also by having the federal government insofar as possible work with the significant private, philanthropic foundations in creating incentives together for all of us to move in positive directions.

The Robert Wood Johnson Foundation is very much to be commended for taking leadership in this role. Perhaps there are other foundations that would also like to join in helping us. It is not just public money. It is private money, too, that is needed to help.

Number three, we very much need the federal government to help us in the public sector and in the private sector with the third party payers. They are used to supporting only the traditional, in-patient service and to a certain extent out-patient visits to psychiatrists and physicians. We need them to be more creative in unbundling their insurance benefits to allow reimbursements under certain circumstances. We know we do more about Medicare in some ways than the public sector for severe mental illness. We need them to be able to be more flexible in unbundling some of their benefits so that we can help these kids.

We are very grateful that you are having these hearings. Community-based services are tremendously cost effective. When these services were developed for adults in our county, we were able to reduce hospital bed stays by 40 percent. We know we can do it for kids.

They are not brand new ideas. Everybody knows what we should do. We need the help in being allowed to do it.

Chairwoman SCHROEDER. Thank you. Thank you very, very much.

[Prepared statement of Sandra Cornelius, Ph.D., follows:]

PREPARED STATEMENT OF SANDRA CORNELIUS, PH.D., PRESIDENT-ELECT, ELWYN, INC., ELWYN, PA; FORMER ADMINISTRATOR, DELAWARE COUNTY DEPARTMENT OF HUMAN RESOURCES, MEDIA, PA

Good morning members of the House Select Committee for Children, Youth and Families. Thank you very much for the priviledge of offering testimony today.

Until mid-March, I was the Human Services Director for Delaware County Government in Pennsylvania. Delaware County, adjacent to Philadelphia County, has 554,000 citizens and a demographic profile less affluent than its suburban neighbors.

Distressed with the large amount of public monies being spent on a relatively small portion of the emotionally distrubed youngsters of the County and aggrevated by the dilution of therapeutic effect secondary to categorical funding restraints, the County with the PA Department of Public Welfare successfully competed for a Robert Wood Johnson Foundation Grant to reorganize the County's service system and the funding mechanisms to support it.

You have heard from prior testimony of the incidence and prevalence of serious emotional disturbance in children and youth. Delaware County did an actual head count of all children known to the public drug and alcohol, mental health, mental retardation, educational and child welfare systems. We can name 2,200 individual children with mental health problems sufficient to require placement away from their families. We're not talking about struggles with discipline or problems performing up to capability in school, we're talking about suicidal ideation, severe depression, psychoses and extremely serious behavior disorders.

The service system problems to be solved were two-fold. First, a very small number of children were getting the majority of available public money. Secondly, most of the available public money was going for inpatient or institutional type services at high unit rate costs. Our analysis concluded that with: 1) comprehensive cross system diagnoses of children and families; 2) expenditure of funds for integrated (non-categorical) service planning and delivery; 3) expenditure of funds on community based (as opposed to inpatient) services such as case management family support services, and socialization, vocational training opportunities, student assistance in school and therapeutic foster care, partial day programming and 4) improved utilization of all currently available County, State and Federal funds, we could effectively support the majority of needy families as they cared for their troubled children.

We could help the families reduce stress and strife, get appropriate educational help, carry out treatment plans and secure medication and therapy where appropriate with families in charge and the service system there to support and assist not to replace families, the vast majority of kids could remain at home.

Two points remain to be made:

First, Delaware County has been able to proceed because it received grant money to establish a second parallel system of care. We had to sustain the facility based care system until the family based system was established. Without the money to "prime the pump", a new system change from the old facility based care system could only be minimal and incremental. An analogy with medical systems seems apt. If all that is available are hospital emergency rooms then medical problems of whatever size and severity will be seen by the emergency team instead of the local general practioner, school nurse or whatever.

Secondly, significant additional support for this system of care would be possible if the private insurance system, including managed care systems, could be encouraged to see the worth of participating in reimbursing non traditional family based types of care instead of the more prevalent practice of reimbursing only for inpatient hospitalization and outpatient viists to physicians and psychiatrists. We believe that sufficient information and experience is being built to help the private insurance system move in this direction. Without a partnership of the public and private system the families with private insurance pay but have fewer therapeutic options available for services that might make a critical difference in the early stages of the child's disturbance.

We commend the Committee for their concern and interest in improving the service system for these troubled children and their families and stand ready to support and facilitate deliberations in any way possible.

Chairwoman SCHROEDER. Dr. Attkisson, please, you are next, and if you can grab the mike so we can hear, thank you and welcome.

STATEMENT OF CLIFFORD ATTKISSON, PH.D., PROFESSOR OF MEDICAL PSYCHOLOGY, DEPARTMENT OF PSYCHIATRY; AND ASSOCIATE DEAN OF GRADUATE DIVISION, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

Dr. ATTKISSON. Thank you very much.

I am here from the University of California where I direct the Child Services Research Group. This is an organization that is funded by the University and by project grants from the National Institute of Mental Health, by a state research contract from the State Department of Mental Health in California, and indirectly through the Robert Wood Johnson Foundation, with the Family Mosaic Project, which is one of the projects funded by RWJ to the State of California and the City of San Francisco.

Two years ago I began work evaluating the efficacy and the cost efficiency of the Assembly Bill 377, which was California legislation designed to implement the Ventura planning model in three other California counties.

The Ventura planning model is a model of integrated mental health services, coordinating with education, social services and the child juvenile justice programs in the various counties.

After a successful demonstration in Ventura County, which I did not participate in as an evaluator, but have reviewed, this California legislation implemented the model system of care in three other California counties, in San Mateo, Santa Cruz and in Riverside Counties.

We now refer to the model system of care not as the Ventura model, but as the California model system of care, in which a series of planning steps are followed to create service plans and case management procedures for individual youth. Administrative structures are also created to allow coordination and monitoring of services to severely emotionally disturbed children, and I want to emphasize that these model systems of care place a strong focus on the reduction of reliance on restrictive levels of care, that is, hospital-based care, such as state hospitals or locked mental health facilities or highly restrictive residential care facilities.

The model system of care also places great emphasis on maintaining children and youth in their homes, if possible, or in enriched, therapeutically informed residential foster care placements, and emphasizes the reduction of use of group home care in the state.

Our job at the University of California is to look at the efficacy of these efforts in the three counties, and our work in San Francisco will also involve the evaluation and monitoring of the Family Mosaic Project, which I think will be a quite innovative application of the Ventura principles within the context initially of a capitated funding system.

In my prepared written statement, I have spelled out in some detail the basic goals of the evaluation of AB 377 and have linked the evaluation of AB 377 in California to our federal grant, and I will not reiterate the details of that, but will focus on a few of the findings that are now currently available.

Our work is a five-year project, and we are now in midstream of the second year, and so the results that I have to tell you about are preliminary and focus mostly on the dollar cost savings and the reduction of use of intensive or restrictive levels of care.

We are interested also in the degree to which these programs reduce arrest or re-arrest of children who are involved in the juvenile justice system, and we are interested in our evaluation in whether or not the educational performance of the target population of the youth is maintained or enhanced.

I would like to emphasize one of our initial major findings, and that is that the model systems of care are tremendously reducing the use of group home services in California. More dollars were spent on group home placements than any other out-of-home placement in California. In 1988-89, for example, $347 million were spent on group home placements.

We estimate $500 million in the current fiscal year will be spent on group home placement. This amounts to almost half of the $728 million spent in out-of-home placements in California during '88-'89. Group homes in California during that period served 11,100 youth.

Now, this number represented 22 percent of the AFDC foster care population, and those 11,000 expended 63 percent of the funds budgeted for AFDC foster care services, and as I have mentioned, these group home services are increasing in cost at a dramatic rate in contrast, for example, to the state hospital program for children, which costs $29 million.

The average annual group home cost per child in California during this period, '88 to '89, was $31,000 per child. This is contrasted with $106,200 per child year in the state psychiatric hospital.

I am emphasizing that both costs are very high, and that as a proportion of out-of-home placement, hospital costs are not as exaggerated in terms of the total as are group home costs, but that both represent an enormous expenditure of public monies.

The model systems of care were designed to reduce the reliance on state hospital and group home costs, and I would like to turn your attention to the findings that we have reported in our written testimony. I will mention one specific finding in my oral presentation.

In one of the figures in our testimony, we indicate that the combined expenditures—these are per capita, inflation adjusted amounts—combined expenditures per child in the total population of these counties was $2.78 per capita, inflation adjusted, and that this was lower than the combined expenditures per population for the total State of California, which was $3.66 per child in the total population.

Let me make some sense of these per capita costs for you. For the two years running from February 1989 to January 1991, the State of California might have saved a total of $171 million in group home costs if the state had followed the trend of AB 377 counties instead of the existing trend in the state.

Furthermore, the savings have, in general, been increasing from month to month over the past two years. A study of these cost factors is supplemented by the evidence that these integrated service programs have been able to reduce the use of group homes and state hospital care by the institution of enriched or therapeutic foster care and the effective interventions with families when families are available.

Because our time is limited, I would like to emphasize one additional point and then summarize some recommendations for you. We have found that children who are at risk for out-of-home placement tend to come from ethnic minority backgrounds, to be non-English speaking or to have a language other than English as the primary language in their home, to experience early separation from their parents, to have experienced physical abuse, as well as sexual abuse, and neglect, and to have lower school and language achievement scores.

They tend to suffer from personality disorders or pervasive development disorders. I want to underscore the prevalence of physical and sexual abuse and neglect among the subject population. A combination of any of these three accounted for something like 67 percent of our total population studied to date.

This is a major, major issue and one of the primary causal factors, we think, in long-term emotional disorder among the children who are at greatest risk. We feel that the programs to date have been effective in reducing out- of-home placement, in controlling costs, and in providing for more stable residential care at a lower cost than the alternative traditional models.

We feel that because of the diversity in geography, population, urban and rural, that the California counties perhaps represent a microcosm of what is present in the nation.

We feel that our findings are generalizable, but it is increasingly important to note that we have lots and lots of vertical plumbing with dollars flowing from the federal to the state to the local communities, but we have very, very poor horizontal plumbing. The integration among our service system agencies is poor. This is true in California as in other places in the nation, as has been reported.

We need to have incentives to produce greater collaboration, cooperation and blended funding across the component agencies.

I would like to conclude by recommending to the committee consideration of factors which I think will enhance the capacity of the federal government to assist in the planning for improved care for children, such as the ones that we are studying.

I would point to the fact that the Head Start Program has been successful not only because it's a good program, but because it was well documented. There were research data available on an ongoing basis that demonstrated the strengths and weaknesses, the correctable problems with that program.

One of the greatest needs that we have is for training support for the next generation of investigators. We need child services research centers which will allow for the intensive programmatic collection of data and the reporting of those data to policy, planning and academic audiences. We need state, local and federal demonstration projects of major magnitude in order to be able to demonstrate what can be done that is effective in reducing costs and increasing quality of care.

My other recommendations are less significant, and I will simply call attention to the fact that we need, as in most social science fields, opportunity to improve our methods and research methods, methodologies, and we need a better capacity at the federal level to disseminate knowledge about innovations.

We know much more about what is effective than has been disseminated across the nation, and we need better mechanisms to do that.

And I thank you for this opportunity.

[Prepared statement of Clifford Attkisson, Ph.D., follows:]

PREPARED STATEMENT OF CLIFFORD ATTKISSON, PH.D., PROFESSOR OF MEDICAL PSYCHOLOGY, DEPT. OF PSYCHIATRY; AND ASSOCIATE DEAN OF GRADUATE DIVISION, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA

SERVICE SYSTEMS FOR YOUTH WITH SEVERE EMOTIONAL DISORDERS: SYSTEM OF CARE RESEARCH IN CALIFORNIA

Clifford Attkisson, Karyn Dresser, and Abram Rosenblatt

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Presented as invited testimony to the United States House of Representatives, Select Committee on Children, Youth, and Families by Clifford Attkisson, Ph.D. on April 29, 1991. Dr. Attkisson is Professor of Medical Psychology, Department of Psychiatry, and Associate Dean of the Graduate Division at the University of California, San Francisco. For additional information, address correspondence to: Child Services Research Group, Institute for Mental Health Services Research, The Central Tower, Suite 400, 703 Market Street, San Francisco, California 94103. [Telephone: 415-957-2919. FAX: 415-957-2918.]

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The Child Services Research Group of the Institute for Mental Health Services Research conducts services research on systems of care for children and adolescents with severe emotional disorders. The Institute for Mental Health Services Research is funded, in part, by a Center Grant from the Division of Applied and Services Research of the National Institute for Mental Health.

Three child services research projects have been developed and funded during the past three years. These projects are now all operational and, viewed together, form a nucleus of complementary investigations. The three current projects constitute a multi-faceted study of the implementation of the California Model System of Care in three California counties. The model care system was derived from pioneering programmatic efforts in Ventura County, California and is designed to integrate four sectors of care that are critical to youth suffering from severe emotional disorders: mental health care, social services, educational programs, and juvenile justice programs (Feltman & Essex, 1989; Jordan & Hernandez, 1990; Ventura County Children's Mental Health Services Demonstration Project, 1988). Following initial demonstrations in Ventura County, alternatives to fragmented, discontinuous, and uncoordinated care for children with the most severe emotional disturbances are being created and implemented in four other California counties. Legislation enabling and financing the expansion of the California Model System of Care (California Assembly Bill 377) stipulated that: (a) public sector resources be expended on behalf of youth with the most severe disorders who are at risk of out-of-home placement (estimated to be approximately 1% of the child population in the demonstration counties); and, (b) that services be integrated across component agencies through continuous case management.

In the California Model System of Care, a series of planning steps are followed to create service plans and case management procedures for individuals within the system of care. Administrative structures are also created to allow coordination and monitoring of services provided to severely emotionally disturbed children and youth in the target population. In the model care system, an emphasis is placed on reduction of reliance on restrictive levels of care, prevention of out-of-home placement especially to state psychiatric hospitals and group homes, maintenance of progressive educational achievement, and reduction of recidivism in the juvenile justice system. Cost containment and cost avoidances are also primary goals of the integrated approach to delivery of services to this most-in-need population.

In the succeeding sections of this report, we present currently available findings from three studies that were designed to evaluate and understand the effects of the California Model System of Care. For each investigation, we present the study design, services research methods, and measures employed in the data collection effort. When available, empirical findings are presented from the initial phase of each investigation.

CURRENT STATUS OF THE RESEARCH

THE CALIFORNIA AB377 EVALUATION PROJECT

1. *Overview.* The AB377 Evaluation Project is a multi-year, collaborative mental health

services research effort between the University of California, San Francisco, the Institute for Mental Health Services Research, and the California State Department of Mental Health (DMH). It is funded by a California DMH contract, was initiated in October of 1989, and is now completing its second year of operation. It is anticipated that this will be a five year study and the California AB377 Evaluation Project is best conceived as evaluation research designed to document and assess the efforts in California to disseminate, implement, and enhance an integrated system of care for children and adolescents having severe emotional disorders. The core focus of the research is the evaluation of the California model system of integrated care for seriously and persistently emotionally disturbed children and adolescents -- the model care system goals pioneered by the Ventura County Mental Health Services (Jordan & Hernandez, 1990).

This California model system of care was designed and its methods initially assessed in Ventura County, California during the mid-1980s. Subsequently, the model has been disseminated to three additional California counties (San Mateo, Santa Cruz, and Riverside) by enabling legislation (Assembly Bill 377). The AB377 legislation included an evaluation component and these state funds support this aspect of our research program. The research team is led by Dr. Clifford Attkisson, serving as principal investigator with Dr. Abram Rosenblatt serving as Associate Project Director. Other investigators involved in this study are Drs. Teh-wei Hu, Lonnie Snowden, and Karyn Dresser. UCSF Postdoctoral investigators include Drs. Gary Blair and Patricia Gribble. At the California State Department of Mental Health, leadership and project management is provided by Dr. Betsy Burke, Thelma Ellison, and Gary Matthies.

The long term, central goal of the AB377 Evaluation Project is to study the implementation of the California Model System of Care within these new environments to determine its costs and effectiveness. A second key, long range goal is to demonstrate a model for a state-wide integrated data system documenting services to children and adolescents. Immediate project goals include: assisting the California DMH in the establishment of performance criteria; assisting the counties in their data collection efforts; monitoring program performance through analysis of data related to the performance criteria; and collecting and integrating data from multiple state and county sources. All data collected and analyzed in this effort are in the form of secondary data provided by the counties and several state agencies. Although individual level client data are included in these data sets, no individual data are directly collected by the services research team from service consumers, providers, or service programs. The available data sets contain excellent cost and service utilization variables but include only the most basic individual outcome data.

2. *The California AB377 Demonstration Counties.* Three counties were awarded State Department of Mental Health contracts and were enabled by AB377 to implement the Ventura model system of care strategy. The three counties, Riverside, San Mateo and Santa Cruz, were selected on the basis of a competitive application process by the State Department of Mental Health. Each of the three counties are substantially different in size and composition.

Riverside is the largest of the three counties (population 1,170,413, under 18 population 333,261) and is the fastest growing county in the State of California. The county is huge in size and extends from eastern Los Angeles to the California/Arizona border. The county has sparsely populated desert areas as well as more densely populated areas such as the city of Riverside which contains a campus of the University of California. Riverside has a substantial Hispanic population (26.7% total, 35.7% under age 18) as well as a significant Black population (5% total, 6% under age 18).

Santa Cruz County is the smallest of the three counties (population 229,734, under 18 population 54,704) and has experienced only moderate increases in population. The county is relatively small in area (in California terms) and extends along the coast and slightly inland just south of the San Francisco Bay area. The county is mostly rural, with the highest population in the city of Santa Cruz, which is a popular vacation destination and also contains a campus of the University of California. The county has a substantial Hispanic population (20% total, 31% under 18), many of whom work in the farming communities in the southern portion of the county. Santa Cruz suffered the most extensive damage of any California county following the highly publicized Loma Prieta earthquake of 1989.

San Mateo County is directly north of Santa Cruz county and extends along the western end of the San Francisco Bay until it joins the City and County of San Francisco. It falls in between the two other counties, both in terms of its population (649,623, with 142,486 under age 18) and its suburban character. The county does not have a dominant population center, but does contain the communities of Palo Alto (home of Stanford University) and the city of San Mateo. The county has substantial Asian (16.2%, 19.6% under 18), Hispanic (17.7%, 25.3% under 18) and Black (5.2%, 6.5% under 18) populations.

3. *Goals of the Evaluation of AB377.* The AB377 Evaluation Project follows the legislative mandate to collect data regarding four important system of care performance criteria: (a) to ensure that the target population is being served as intended, (b) to reduce reliance on restrictive levels of care, especially reliance on state hospital and group home admissions, (c) to reduce the likelihood of re-arrests for youth in the target population who are involved in the juvenile justice system, and (d) to improve the educational performance of target population youth in school settings.

Data collection efforts in the California AB377 Evaluation Project began in October of 1989, under contract with the California State Department of Mental Health. The evaluation project is a longitudinal study that is expected to go forward for five years. Data are now available for selected variables related to the AB377 performance criteria. For other variables of interest, data will not be available for another six months due to the longitudinal nature of the study and the fact that educational achievement scores, recidivism rates, and state hospital use rates must, by their nature, be collected and analyzed at the end of the investigation's major data collection cycle.

In the following pages we present a synopsis of key findings that are currently ready for dissemination.

4. *AB377 Evaluation Project Findings to Date.*

(a) Characteristics of Youth Served. Data are being collected to determine if the AB377 Counties are serving the designated target population of youth with severe emotional disorders who are either in out-of-home placement or judged to be at risk for out-of-home placement. In prior research, risk for out-of-home placement has also been associated with several other factors, including especially: (a) ethnic minority status, (b) history of abuse and neglect, (c) having a primary language other than English, and (d) having a clinical diagnosis of affective disorder, conduct disorder, or attention deficit disorder (Cornsweet, Rosenblatt, Harris & Attkisson, 1991). In the AB377 Evaluation Project, we are collecting data on the clinical diagnosis and ethnicity of youth served by the AB377 programs. Data on language spoken and history of abuse and neglect will be collected in our other projects to supplement what can be collected with available State funds. Data are currently available for two of the three counties with a third county still in the process of reporting the results.

In Santa Cruz county, 72% of the youth served are white, compared to 74% of the county's total under age 18 population. Another 17% of the youth served are Hispanic, compared to 17% of the under age 18 population. An additional 3% of the youth served are Black, matching the 3% of the total under age 18 population that is Black. In short, the ethnic breakdowns of the youth served in Santa Cruz are almost identical to the ethnic breakdowns of the general population under 18.

In San Mateo county, the youth served by the AB377 programs are less representative of the total population. The proportion of whites served by the programs and of whites under 18 in the county are roughly equivalent (45% for the youth served, 48% for the under 18 population). However, Blacks are over-represented in the target population, representing 18% of those being served but only 6% of the population under 18. Asians, on the other hand, are under-represented in the target population, representing only 4% of the target population but 20% of the population under 18. Finally, Hispanics are slightly under-represented in the target population (18% for the youth served, 25% for the under 18 population).

Therefore, both Santa Cruz and San Mateo seem to be serving fair representations of their overall population. In Santa Cruz, the service population mirrors the population as a whole. This is probably because the population is mostly Hispanic and White, two groups which are usually receive mental health services in proportion to their numbers in the general population. In San Mateo, the service population is characterized by an under representation of Asians and an over-representation of Blacks. This trend is commonly found in studies of mental health utilization. No data were available for Riverside county regarding the ethnicity of their target population at this time.

The clinical diagnoses upon admission to the systems of care for Santa Cruz and San Mateo counties were similar between the two counties. Disruptive behavior disorders were the most prevalent diagnoses in both counties (34% of the youth served in San Mateo and 59% of the youth served in Santa Cruz). The second most prevalent diagnoses in both counties were the mood disorders (22% in San Mateo, 28% in Santa Cruz). Anxiety disorders were the third most prevalent group in both counties (5% in San Mateo, 10% in Santa Cruz). Therefore, the rates and proportions of the diagnoses given to youth by clinicians upon admission to the systems of care are fairly similar for these two counties and match what would be expected given prior research. Again, diagnoses were not available for Riverside County.

(b) Reliance on Restrictive Levels of Care.

Group Homes. The analysis of group home expenditures has been the most central task of the evaluation to date. There are two primary reasons for this focus: (a) the alarming rise of costs associated with group home placements of youth in California; and (b) the focus of the Ventura Demonstration and the AB377 counties on reducing group home placements and costs as a central element of the newly organized systems of care.

A recent publication summarizes the importance of group home placements and costs in the State of California (*Ten Reasons to Invest in the Families of California*, 1990). The following important points are gleaned from this recent publication. First, in fiscal year 1988-89, more dollars were spent on group home placements than any other out-of-home placement option ($347 million). These funds amounted to almost half of the $728 million spent on out-of-home placements in California. In 1989, group homes in California served a population of over 11,100 youth and this number represented 22% of the AFDC-foster care population. These 11,100 expended 63% of the funds budgeted for AFDC-foster care services. Furthermore, group home costs are rising at an alarming rate when viewed at the state-wide aggregate cost level. As a comparison, the total cost of placing youth in California State Hospitals was $29 million in fiscal year 1988-89, less than 10% of the total amount expended on group homes. In fact, group home placement is second only to state hospital admission as the most costly alternative when children are placed out-of-home. The average annual group home cost per child is $31,100 compared with $106,200 per child per year in the state psychiatric hospital.

Group home facilities themselves vary tremendously, from those relatively small in size (4-10 beds) to over 100 bed structures that physically resemble psychiatric hospitals. The facilities are defined by the department of social services as "a nonsecure, privately operated residential home of any capacity, including a private child care institution, that provides services in a group setting to children in need of care and supervision, and which is licensed as a community care facility by the department". Through fiscal year 1990, group homes were classified according to four models:

(1) *Family*: These homes are primarily designed to provide socialization for children who do not display age-appropriate social and relationship skills. Little or no psychiatric and psychological services are provided.

(2) *Psychiatric*: These group homes are primarily designed to treat children with diagnosed psychiatric problems. Full time staff provide direct psychiatric services to all children in the facility.

(3) *Psychological*: These are intended to treat underlying emotional and psychological problems of children and families and to address behavioral issues. Part-time staff provide direct psychological services to all children.

(4) *Social*: These are meant to treat children exhibiting social behavioral problems who do not evidence marked emotional problems. Part time staff provide direct psychological services to some children.

Surprisingly little is known about the youth who reside in these homes. The vast majority (approximately 70%) of youth are placed because of parental neglect, incapacity or absence. The remainder are placed because of sexual or physical abuse. The underlying reasons for these placements are not known and we do not know, in the scientific meaning of "know", what proportion of youth have diagnosable psychological or psychiatric disorders. However, in 1987, 70% of the children placed in group homes resided in either the "psychiatric" or the "psychological" homes which are designed to provide some type of mental health services. Furthermore, "psychiatric" and "psychological" types of homes constituted 89% of the newly licensed programs in 1987. Finally, it was estimated that *only 10%* of all children in group homes receive services from local departments of mental health. In essence, the group home program in California represents a de facto mental health system, outside of the formal mental health apparatus, for youth who primarily suffer from parental absence, abuse and/or neglect.

Group Home Expenditures. The cost data we have collected encompasses the combination of all four types of group homes funded within the state. The data we have analyzed represents funds expended through the Aid for Families and Dependent Children-Foster Care (AFDC-FC) program and the data are provided by the California Department of Social Services. The amounts currently available for analysis reflect only these expenditures and therefore are not inclusive of total group home costs. We estimate, however, that approximately 90% of public expenditures for group home placements are now captured by our analyses. The largest proportion of non-captured costs resides in expenditure contributions made through the mental health sector where we now know that approximately 7% of the children in group homes receive supplemental funding through a mental health "patch".

The AFDC-FC costs for the AB377 counties were analyzed by comparing them to the aggregate AFDC-FC costs for the State of California. The use of California as a comparison provides a baseline against which to judge progress of the AB377 counties in achieving programmatic and cost-saving goals. In order to compare counties with each other and with the State, the county costs and the state costs are adjusted for the number of youth residing in the appropriate geographic areas. Therefore, the comparison data are expressed as per capita amounts. The per capita costs were calculated by dividing the group home costs in each county by the number of youth in each county (defined as persons under 18 years of age). The same calculation was performed for the State of California as a whole, by dividing the total costs for California by the number of youth in the state. When these comparisons are made, the AB377 counties, taken together, have lower per capita expenditures and a lower rate of increase in per capita cost over time than the state aggregate per capita costs. Figure 1.0 illustrates these trends in inflation adjusted dollars. Figure 1.0 indicates that the combined expenditures per population of all the AB377 counties (currently at $2.78) is lower than the combined expenditures per population for the total State of California (currently at $3.66). As Figure 1.0 displays, the group home expenditures for the AB377 Counties and the State were roughly the same until the middle of 1986. This is approximately one year after the Ventura demonstration project began. There is substantial external evidence to demonstrate that the AB377 counties had already begun to implement the system of care modeled in Ventura county by the middle of 1986 (see also Figures 1.1, 1.2, and 1.3 for data at the individual county levels).

Estimated Cost Savings. The per-capita dollar differences between the AB377 counties and the State of California can be converted to overall dollar differences by multiplying by the population in the state. This calculation shows the amount of money the state could have saved if the state were able to spend per-capita amounts at the per-capita rate demonstrated by the AB377 study counties. We decided to begin cost-saving calculations as of February, 1989, since this is the date when the contracts providing funding for the systems of care began. This data provides a fair and conservative starting point, though clearly expenditure savings could have occurred before this date.

For the two years running from February, 1989 to January, 1991, the State of California might have saved a total (in actual, non-inflation adjusted dollars) of $171,132,063 in group home costs if the State of California had followed the trend of the AB377 counties instead of the existing trend in the state. Furthermore, the savings have, in general, been increasing from month to month over the past two years.

These estimated cost-saving totals do not calculate the costs that go into providing alternative forms of care for the youth. However, given that group home placements are second only to hospitalizations in costs per placement, it is sensible to assume that other forms of care provided to the youth would not completely offset these savings. Nonetheless, this issue will require further investigation. Finally, since the figures we present are per capita and inflation adjusted, these results do not seem to be due to changes in population or the value of money.

(c) *Impact on Juvenile Justice Recidivism and Re-arrests.* To assess the impact of the systems of care on AB377 target population youth who have contact with the Juvenile Justice system, the rate of re-arrests for these youth is being measured as is the severity of the crime in the instance of a re-arrest. These variables are being monitored for the year preceding incarceration and the year following incarceration for each individual. These data must be originally collected by the counties (e.g. it does not reside in existing information systems). At this time, only one county, Santa Cruz, has made re-arrest data available. The other two larger counties are still working on collecting the required information. The Santa Cruz data are in raw form and base rates for re-arrests in the county must be determined before the available data can be interpreted.

(d) *Impact on School Attendance and Achievement.* Data on school attendance and school achievement test scores are being collected to assess the impact of the system of care on the school performance of youth in the target population who are being served in school-based programs. Again, this involves original data collection on the part of the counties so that to date, preliminary data are only available for Santa Cruz. Analysis of data from all counties will be undertaken over the summer months of 1991 after the end of the current school year.

CLINICAL EPIDEMIOLOGY IN THREE SYSTEMS OF CARE FOR YOUTH

1. *Overview.* Once the AB377 Evaluation Project contract with California DMH was implemented, we sought National Institute of Mental Health support for a longitudinal study of clinical incidence and prevalence of mental disorder, service utilization, and cost-outcomes within two of the AB377 counties and a control county. This research grant application was submitted April 10, 1989, and a notice of award was subsequently approved with funding beginning October 1989. The research project, "Clinical Epidemiology in Three Systems of Care for Youth," (funded by the NIMH Division of Applied and Services Research) includes individual level data collection on diagnosis, clinical status and outcome, utilization of services, and cost of care. The research team is led by Dr. Clifford Attkisson, serving as principal investigator with Dr. Karyn Dresser serving as Co-Investigator and Associate Project Director and Dr. Abram Rosenblatt as Co-investigator. Other investigators involved in this study are Drs. John Jemerin, Teh-wei Hu, Emily Harris, Luz-Mary Harris, and Lonnie

Snowden. UCSF Postdoctoral investigators include Drs. Gary Blair and Patricia Gribble.

2. *Preliminary Research Findings.* Preliminary investigations conducted by members of our services research team focused on at-risk youth who have multiple residential placements over time coupled with a high rate of use of restrictive levels of mental health care. Findings from these studies of San Francisco children and adolescents indicate that "multiple placement" youth (those having high rates of out-of-home placements and changes in residential location) were found to come from ethnic minority backgrounds, to be non-English speaking, to be male, to have experienced early separation from their parents, to have experienced physical abuse as well as sexual abuse and neglect, to have lower language achievement scores and to have been given a clinical diagnosis of personality disorder or pervasive developmental disorder (Cornsweet, Rosenblatt, Harris, & Attkisson, 1991). Similar results were found when predicting number of inpatient admissions except that clinical diagnoses tended to be more severe, including most frequently psychotic disorders and major affective disorders. When inpatient psychiatric admissions are excluded from the number of total placement changes, several variables assumed special prominence in predicting a high rate of out-of-home placement: the presence of physical abuse, clinical diagnosis of affective disorders, early separation from a caretaker, a high overall symptom count, and male gender status.

Of the 192 children and adolescents in the Cornsweet et al. (1991) study of San Francisco youth served in restrictive or very intensive levels of mental health care, a large portion of the sample had suffered some type of physical abuse or neglect. "In some cases instances of abuse and neglect overlapped; however two-thirds (67%) of the youth had "definitely" or "possibly" experienced some type of abuse or neglect. Physical abuse was most frequent (definite in 31% of the cases, possible in an additional 17%), followed by neglect (26% definite, and 17% possible) and sexual abuse (17%

definite, 16% possible)." " The incidence of physical abuse and of neglect were equally high among males and females. Sexual abuse, however, was more prevalent among females than males, with 33% of females in the sample "definitely" and an additional 26% "possibly" suffering sexual abuse, versus 10% and 12%, respectively, of the males. However, incidence of sexual abuse is believed to be generally under-reported for male youth and therefore the observed clinical prevalence among males in the Cornsweet et al. study may be an under-estimation of true prevalence."

These preliminary findings, based on data abstracted from service program records and data bases, lead to the development of a prospective design that allows control of a number of additional variables and more precise measurement of variables of interest. Specifically, we included: multiple sites; a representative sample of youth from all sectors of the total system of services; research diagnostic interviews; and a more reliable assessment of socioeconomic status, social functioning, history of abuse and neglect, and more rigorous assessment of service use history across the spectrum of services. The enhanced design features were incorporated within the NIMH federal grant proposal that was funded.

3. *Federal Grant Research Goals and Design.* The NIMH-funded research project encompasses a comparative study of three county systems of mental health and related services for severely emotionally disturbed youth and their families. It is inspired by our preliminary investigations and a number of trends in California and the nation which make crucial the need for systematic epidemiologic research. The costs of mental health care for youth have increased progressively and services for youth must now compete with vexing, refractory problems in mental health service delivery to the adult population (Dougherty, Saxe, Cross, & Silverman, 1987; Inouye, 1988; National Advisory Mental Health Council, 1990; Saxe, Cross, & Silverman, 1988; Tuma, 1989). In the mental

health sector, the use of acute and long term hospitalization and residential placements has greatly increased over the past decade. The social welfare system has placed more children and adolescents in shelters, foster care, and especially in costly group homes. The juvenile justice system is detaining and incarcerating more youth. There is growing concern that this pattern of treating children and adolescents in costly, restrictive environments may be clinically inappropriate and fiscally insupportable. Little is known about the diagnostic profiles of these youth or the range of human service needs they experience (Brandenburg, Friedman, & Silver, 1990; National Advisory Mental Health Council, 1990). Our NIMH-funded research project aims to address these important information needs.

The study population of interest contains children and adolescents (age six through twenty-two) with mental disorders who have been or will be identified by the counties' service systems as being currently in an out-of-home placement or at-risk of being placed out-of-home. The at-risk criteria define eligibility of youth for a system of care built upon the principles of interagency coordination, case management, cultural sensitivity and competence, and least restrictive placement. The children and youth in our sample are those who are currently receiving services in the model care systems (or the control system) or who have been identified as eligible for entry into the systems of care.

San Mateo, Santa Cruz, and San Francisco Counties are the three counties participating in this aspect of our research. San Mateo and Santa Cruz are AB377 demonstration counties and are in the early implementation phase of their new system of care. San Francisco County serves in the study as the control county without a model care system in place at the inception of the study. These differing starting points and the steps along the way in the development of the model systems of care will be subject to descriptive analysis. San Francisco has now planned a model system of care but its implementation will lag the other two counties in our NIMH-funded project by at least two years; thereby allowing San Francisco to serve as a control county for the first phase of the research. Plans for a system of care in San Francisco will be described in the next major section of this report.

The central task of the research will be the collection of data from two random samples of children and youth within each county system: (a) prevalence samples -- measuring the rates and distributions of disorders among eligible youth throughout the service systems; and, (b) incidence samples -- measuring the rate of identification of new cases, those newly identified to be at risk. Portions of both of these samples will be re-interviewed for complete further clinical assessment during a follow-up sampling phase and all the youth will be traced on utilization and cost variables over time. The two types of sampling, incidence and prevalence, will allow an assessment of the distributions of disorders among those who are newly at risk of out-of-home placement or exposure to restrictive levels of care (incidence of new cases during a fixed time frame) and those who are known to be at risk at a fixed point in time (prevalence). The planned followup of the incidence and prevalence samples (along with a new incidence sample after two years) will allow a sensitive assessment of the effects of system change on the youth being served. Additionally, small samples from a broader net (the "discovery points" in the community where signs of serious emotional disturbance often first becomes evident) will be screened. Each prevalence and incidence measurement period will last approximately six months, and it is anticipated the project will take five years to completion.

In conducting the study, the latest version of the DSMIII-R based Diagnostic Interview Schedule for Children (DISC) will constitute the clinical diagnostic interview for youth aged 11 through 17 (Costello, Edelbrock, Dulcan, & Kalas, 1984; Costello, Edelbrok, & Costello, 1984; Edelbrok & Costello, 1988; Gutterman, O'Brien, & Young, 1987). An alternate clinical interview, the K-SADS will be used for children under age 11 (Anderson, Williams, McGee, & Silva, 1987; Cohen, O'Conner, Lewis, Velez, & Malachowski, 1987; Costello, 1989; Gutterman et al., 1987). Behavior and symptom data will be collected using the Child Behavior Checklist, the Teacher's Report Form and the Youth Self Report, (Achenbach & Edelbrock, 1983; Achenbach & Edelbrock, 1986; Achenbach, Edelbrock, & Howell, 1987; Achenbach, McConaughy, & Howell, 1987), as well as additional background information about the child and their family. These clinical and functioning data will be related to individual global functioning data (Green, Nguyen, & Attkisson, 1979; Shaffer, Gould, Brasic et al., 1983), service system and administrative diagnoses, utilization data, and cost of services data. The initial wave of data are now being collected on the prevalence and incidence samples in the three counties. The screening samples will be collected during the summer of 1991. These data will be available for analysis during the fall of 1991 and initial reports will be available for the field by mid-winter of 1992.

ROBERT WOOD JOHNSON FOUNDATION MENTAL HEALTH SERVICES FOR YOUTH INITIATIVE

Concurrent with submission for the NIMH research award and the initial phase of the AB377 Evaluation Contract, our research team also consulted with San Francisco County and the California Department of Mental Health regarding the California grant application submission to the national competition for the Robert Wood Johnson Foundation (RWJ) Mental Health Services for Youth Initiative. Subsequently, California was awarded a one year development grant and Drs. Karyn Dresser and Clifford Attkisson assisted San Francisco and the State in grant planning, through collection of pilot data, and in writing the second-phase major proposal. The major proposal was formally submitted and a notice of award was received in July of 1990. Implementation of the major project in San Francisco involves a modification of the Ventura model care system and our research team will be responsible for the installation of a relational data base system that will be the primary administrative information system, clinical data base, and planning system for the RWJ project in San Francisco. This aspect of our work will formally begin in April 1991, after a contract for services is finally executed. The major project in San Francisco is called the Family Mosaic Program and this effort is directed by Abner Boles, Ph.D. The Family Mosaic Project reflects the AB377 model care system goals and aspires to chart new territory in financing care for youth with severe emotional disorders. Betsy Burke, Ph.D. has provided State Department of Mental Health leadership in the development of the California application to the Robert Wood Johnson Foundation.

FUTURE DIRECTIONS FOR THE RESEARCH PROGRAM

The three major projects now underway (the California AB377 system of care evaluation, the NIMH-funded "three systems of care" grant, and the Family Mosaic/RWJ Initiative project) constitute a multi-faceted approach to research on services to youth with severe emotional disorders. The three projects are integrated and complement each other in multiple ways. The resulting data and findings should be a major contribution to the permanent child services research literature. All of the projects are in the initial phase of implementation and several preliminary reports have been made at scientific meetings on the research process to date (Attkisson, Dresser, & Rosenblatt, 1990; Attkisson, Harris, & Dresser, 1989; Attkisson, Rosenblatt, & Dresser, 1990; Cornsweet, Rosenblatt, Harris, & Attkisson, 1991). In addition, two literature reviews have been initiated -- one focusing on measurement and assessment of clinical epidemiology of child disorder across service system components and sectors (Dresser, Attkisson, & Rosenblatt, in preparation) and one focusing on utilization and outcome of care among minority youth with severe mental and emotional disorders (Snowden, Dresser, Attkisson, & Rosenblatt, in preparation).

GENERALIZING THE FINDINGS TO THE NATION

Clearly, our studies focus on four California counties. However, our findings should be generalizable not only to the whole rest of California, but the nation as a whole. With respect to California, the counties participating in our studies include rural, suburban and urban areas in both the northern and southern portions of the state. There is tremendous geographic, social and ethnic diversity within these counties, ranging from coastal regions to deserts, from cities to farms, from some of most affluent regions in the state to some of the poorest. The model care system is being actively considered for implementation in additional California counties, with state-wide implementation being the stated goal of the California Department of Mental Health. Little doubt exists as to the key importance of our study findings in either encouraging, or discouraging, state-wide implementation of the model that began in Ventura county.

With respect to generalizing our findings to the nation as a whole, we argue that the change efforts under way in California are in response to the types of problems found in most other States across the nation. In fact, models of care based on, or similar to the Ventura model, are being implemented and studied in a variety of states across the country (a prominent example of a related, but different system of care exists in North Carolina--Behar, 1985). Finally, California is the largest, and arguably most culturally and ethnically diverse state in the nation. Many of the pressures faced by the state today are liable to constitute and foreshadow the pressures and challenges faced by other states in the future.

Historically, the service and financing systems, primarily designed to meet the needs and characteristics of the adult population, have been inadequate for meeting the complex educational, social, and developmental needs of severely emotionally disturbed children and their families or caretakers (Saxe, Cross & Silverman, 1988; Tuma, 1989). Similarly, research on children's mental health needs and services has lagged significantly behind research on adult populations (Dougherty, 1988).

In recent years, increased attention has been focused on the mental health needs of children (Saxe, Cross, & Silverman, 1988; Tuma, 1989). Beginning in 1969, the Joint Commission on the Mental Health of Children (Joint Commission, 1970) concluded that this population was grossly under-served or inappropriately served in more restrictive settings than were necessary. Again in 1978, the President's Commission on Mental Health (President's Commission, 1978) identified emotionally disturbed children and adolescents as a critically under-served population. More recently, the Institute of Medicine released an extensive report on children and adolescents with mental, behavioral and developmental disorders which again pointed to the need to more effectively research the causes, risk factors, and ways to decrease the impact of mental disorders in this population (IOM, 1989). This report was followed by the National Institute of Mental Health *Plan for Research on Child and Adolescent Disorders* (National Advisory Mental Health Council, 1990). These landmark commission findings have been supported by numerous reports by professionals in the field, which consistently address the need to increase services in the context of an integrated network of service agencies (Coren & McKale, 1985; Inouye, 1988; Julius, Lipton, Pettifor & Smith, 1980; Knitzer, 1982;

Rae-Grant, 1976).

Furthermore, several attempts have also been made at the federal and state levels to improve children's services through legislative action (Dougherty, 1988). Unfortunately, most of the enacted legislation has acknowledged or identified needs, without providing the necessary funding to implement services (Saxe et al., 1988). When legislation stipulates approaches to treatment without providing additional resources, providing the mandated services necessitates cuts in other areas, and the entire system suffers. Federal legislation such as PL94-142 mandating free public education and related services (including mental health services for handicapped children) have been effective because they have been designed as entitlement programs, with funding that is not impacted by local priorities.

As one example of Federal intervention, the National Institute of Mental Health (NIMH) developed the Child and Adolescent Service System Program (CASSP), designed to provide assistance to states and communities to develop comprehensive, coordinated systems of care for severely emotionally disturbed children and adolescents (National Institute of Mental Health, 1983). A guiding principle in these efforts is the focus on interagency collaboration. This agency is actively involved in many states' current efforts to study needs and improve services to this difficult population of SED children and adolescents.

In sum, what is happening in California is not unlike what is happening in the rest of the country. In fact, California currently stands at the leading edge of both the potential problems and potential solutions of treating the youth who suffer from serious emotional disorder.

PROPOSED ROLE FOR THE FEDERAL GOVERNMENT IN SUPPORTING RESEARCH ON SYSTEMS OF CARE FOR YOUTH WITH SEVERE EMOTIONAL DISORDERS

System of care research in the mental health field is a very recent development. This is especially true in the area of child and adolescent services where there are few established investigators and only a very few organized research teams. It is a field that greatly needs attention, encouragement, and fiscal support. Several steps need to be taken to make this a viable and productive line of inquiry -- a line of inquiry that is greatly needed as a key component within the mental health research capacity of the nation. The list of recommendations provided below represents our own views but contains selected themes and recommendations that emerged from the recent *Report of the NIMH Child Mental Health Services Research Planning Workshop* (Commonwealth Institute for Child and Family Studies, Virginia Commonwealth University; and the Research and Training Center for Children's Mental Health, Florida Mental Health Institute; December, 1990):

1. *Training support for the next generation of investigators.* Research training programs need to be established and/or strengthened in the child services research and system of care fields. Predoctoral stipends, dissertation year fellowships, and postdoctoral support is needed for at least six new major training programs in this area. Each should be structured to link educational resources of major research universities with public sector/service sector partners.

2. *Child mental health service research centers.* At least six child mental health service research centers should be developed and coordinated with the human research resources training programs recommended above.

3. *Research demonstration projects.* Major research demonstration projects are needed for the development and dissemination of new knowledge in the child services research and system of care

field. These should be long term projects coordinated at the federal, state, and community levels and should involve centrally the child services research centers and training programs in collaboration with regional, state, and community service programs.

4. *Development of Measures and Research Methodology.* Measures of individual and social system functioning are greatly in need and support for measurement development should be targeted for capacity building in university and research institutes. There is also a great need for dissemination of innovations in biostatistics to this applied research area and innovations in statistical applications and methods need to be encouraged.

5. *Stimulation of Innovation in the Organization and Financing of Systems of Care for Children and Adolescents with severe mental disorders.* Innovation is greatly needed in the way services are organized and financed. Innovations will require integration of knowledge and creativity from the social and clinical sciences including social system theorists, health economists, legal scholars, and public administrators. Mechanisms for integrating such knowledge must be evaluated and adopted.

6. *Dissemination of Innovations.* Mechanisms for dissemination of innovation in the child services research field are greatly needed -- as is true for the services research field in general. Needed change in service systems lags due to the difficulties in disseminating knowledge that requires social, legal, and organizational change. Currently and historically, to a great extent, major innovations and bodies of new knowledge are ignored; service system change occurs only when made inevitable by fiscal crisis.

REFERENCES

Achenbach, T.M., & Edelbrock, C.S. (1983). Manual for the Child Behavior Checklist and Revised Child Behavior Profile. Burlington, Vermont: Department of Psythiatry, University of Vermont.

Achenbach, T.M., Edelbrock, C.S. (1986). Manual for the Teacher's Report Form and Teacher Version of the Child Behavior Profile. Burlington, Vermont: Department of Psychiatry, University of Vermont.

Achenbach, T.M., Edelbrock, C., & Howell, C.T. (1987). Empirically based assessment of the behavioral/emotional problems of 2 and 3 year old children. Journal of Abnormal Child Psychology, 15, 629-650.

Achenbach, T.M., McConaughy, S.H., & Howell, C.T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. Psychological Bulletin, 101, 213-232.

Anderson, J.C., Williams, S., McGee, R., & Silva, P.A. (1987). DSM-III disorders in pre-adolescent children. Archives of General Psychiatry, 44, 69-76.

Attkisson, C.C., Dresser, K.L., & Rosenblatt, A. (1990). Evaluating systems of care: An overview of the Ventura Model. A paper presented at: "A System of Care for Children's Mental Health: Building a Research Base." The third annual meeting of a conference sponsored by the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, Tampa, Florida.

Attkisson, C.C., Harris, L.M., & Dresser, K.L. (1989). Mental health services for children and adolescents in a multi-cultural urban environment. A paper presented at the Conference on

Minority Mental Health Services Research sponsored by NIMH in Honolulu, Hawaii.

Attkisson, C.C., Rosenblatt, A., & Dresser, K.L. (1990). Assessing systems of care for severely emotionally disturbed youth in three California counties. A paper presented at the annual meeting of the American Public Health Association sponsored by the Mental Health Section of APHA in New York City.

Attkisson, C.C. (1990). The next generation of outcome studies. A paper presented at a symposium titled "The Future of Mental Health Services" at the annual meeting of the American Public Health Association in New York City.

Brandenburg, N.A., Friedman, R.M., & Silver, S.E. (1990). The epidemiology of childhood psychiatric disorders: Prevalence findings from recent studies. *Journal of the American Academy of Child and Adolescent Psychiatry*, *29*, 76-83.

Commonwealth Institute for Child and Family Studies, Virginia Commonwealth University; and the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida. (December, 1990). *Service Delivery and Systems of Care Research on Child and Adolescent Mental Disorders. Report of the NIMH Child Mental Health Services Research Planning Workshop.*

Coren, H. Z., & McKale, M. A. (1985). Community Mental Health unraveling: The folly of cost containment. *American Journal of Orthopsychiatry*, *55*, 618-619.

Dougherty, D. (1988). Children's mental health problems and services: Current federal efforts and policy implications. *American Psychologist*, *43*, 808-812.

Cohen, P., O'Conner, P., Lewis, S., Velez, N., & Malachowski, B. (1987). Comparison of DISC and K-SADS-P interviews of an epidemiological sample of children. *Journal of the American*

Academy of Child and Adolescent Psychiatry, 26, 662-667.

Cornsweet, C., Rosenblatt, A.B., Harris, L., & Attkisson, C.C. (1991). Use of mental health services among severely emotionally disturbed children and adolescents in San Francisco. A paper presented at the annual meeting of the American Orthopsychiatric Association.

Costello, A.J., Edelbrock, C.S., Dulcan, M.K., & Kalas, R. (1984). Testing of the NIMH Diagnostic Interview Schedule for Children (DISC) in a clinical population. (Contract No. RFP-DB-81-0027.) Rockville, Md.: Center for Epidemiologic Studies, National Institute for Mental Health.

Costello, E.J. (1989). Developments in child psychiatric epidemiology. Journal of the American Academy of Child and Adolescent Psychiatry, 28, 836-841.

Costello, E.J., Edelbrok, C.S., & Costello, A.J. (1985). Validity of the NIMH Diagnostic Interview Schedule for Children: A comparison between psychiatric and pediatric referrals. Journal of Abnormal and Child Psychology, 13, 579-595.

Dougherty, D.M., Saxe, L.M., Cross, T., & Silverman, N. (1987). Children's mental health: Problems and services. A report by the Office of Technology Assessment. Durham: Duke Press Health Policy Studies, Duke University Press.

Dresser, K.L., Attkisson, C.C., & Rosenblatt, A. (in preparation). Clinical epidemiology across service system components and sectors: A literature review of empirical studies assessing mental and emotional disorders among children and adolescents.

Edelbrock, C., & Costello, A.J. (1988). Structured psychiatric interviews for children. In Rutter, M., Tuma, H., & Lann, I. (Eds.), Assessment and diagnosis in child psychopathology. New York: Guilford Press, 87-112.

Feltman, R., & Essex, D. (1989). The Ventura Model: Presentation package. [Available from: Randall Feltman, Director, Ventura County Mental Health Services, 300 Hillmont Avenue, Ventura, California 93003.]

Green, R.L., Nguyen, T.D., & Attkisson, C.C. (1979). Harnessing the reliability of outcome measures. *Evaluation and Program Planning*, *2*, 137-142.

Gutterman, E.M., O'Brien, J.D., & Young, J.G. (1987). Structured diagnostic interviews for children and adolescents: Current status and future directions. *Journal of the American Academy of Child and Adolescent Psychiatry*, *26*, 621-630.

Inouye, D.K. (1988). Children's mental health issues. *American Psychologist*, *43*, 813-816.

Jordan, D.D., & Hernandez, M. (1990). The Ventura Planning Model: A proposal for mental health reform. *The Journal of Mental Health Administration*, *17*, 26-47.

Joint Commission on the Mental Health of Children (1970). *Crisis in child mental health: Challenge for the 1970's*. New York: Harper and Row.

Inouye, D. K. (1988). Children's mental health issues. *American Psychologist*, *43*, 813-816.

Institute of Medicine (1989). *Research on children and adolescents with mental, behavioral, and developmental disorders.* National Academy Press: Washington, D.C..

Julius, S, Lipton, H., Pettifor, J. L., & Smith, S. (1980). Problems in making organizational systems work for children. *Canadian Psychology*, *21*, 116-120.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, D.C.: Children's Defense Fund.

National Advisory Mental Health Council. (1990). *A National Plan for Research on Child and Adolescent Mental Disorders.* A report requested by the United States Congress.

President's Commission on Mental Health (1978). Report of the President's Commission on Mental Health. Washington, D.C.: Government Printing Office.

Rae-Grant, N. I. (1976). Roadblocks and stopgaps: A review of factors obstructing the development of comprehensive child mental health services. Canadian Psychiatric Association Journal, 21, 433-441.

Rosenblatt, A., & Attkisson, C.C. (in preparation). The measurement of outcomes in mental health services research.

Rosenblatt, A., & Attkisson, C.C. (1991). The California AB377 evaluation project: Initial findings. In preparation.

Saxe, L., Cross, T., & Silverman, N. (1988). Children's mental health: The gap between what we know and what we do. American Psychologist, 43, 800-807.

Shaffer, D., Gould, M.S., Brasic, J. et al. (1983). A Children's Global Assessment Scale (CGAS). Archives of General Psychiatry, 40, 1228-1231.

Snowden, L.R., Dresser, K.L., Attkisson, C.C., & Rosenblatt, A. (in preparation), Utilization and outcome of care among minority youth with severe mental and emotional disorders: A review of the literature.

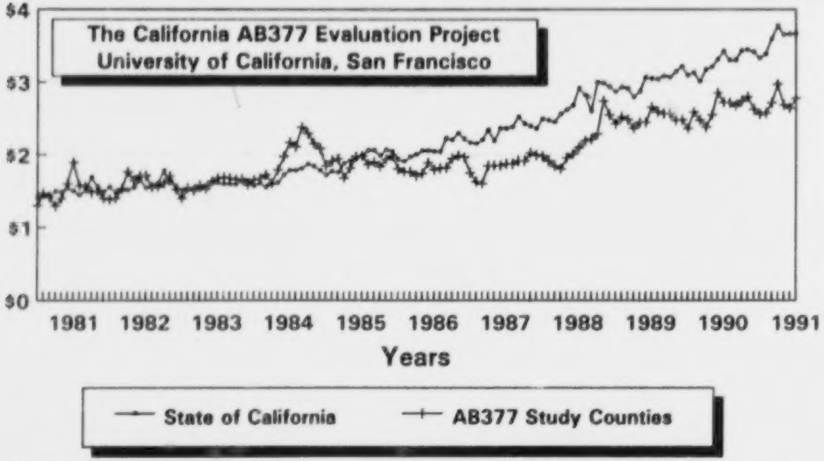
Ten reasons to invest in the families of California: Reasons to invest in services which prevent out-of-home placement and preserve families. Prepared and published by County Welfare Directors Association of California, Chief Probation Officers Association of California, and the California Mental Health Directors Association through a grant from The Edna McConnell Clark Foundation, Spring 1990.

Tuma, J.M. (1989). Mental health services for children: The state of the art. American Psychologist, 44, 188-199.

Ventura County Children's Mental Health Services Demonstration Project. (1988). Final report on the Ventura County Children's Mental Health Demonstration Project: A 3 year update and addendum to the Two Year Report on the Ventura Model for Interagency Children's Mental Health Services. [Available from: Randall Feltman, Director, Ventura County Mental Health Services, 300 Hillmont Avenue, Ventura, California 93003.

FIGURE 1.0

California and Combined AB377 Counties
AFDC-FC Group Home Expenditures
Inflation Adjusted per Capita*

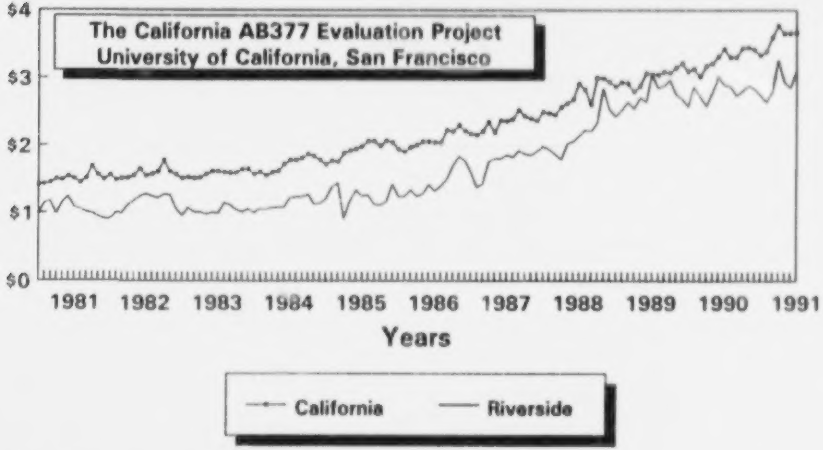


*based on the CPI, populations under 18
(comboinf.cht)

Source: Rosenblatt & Attkisson (1991)

FIGURE 1.1

State of California and Riverside County
AFDC-FC Group Home Expenditures
Inflation Adjusted per Capita*



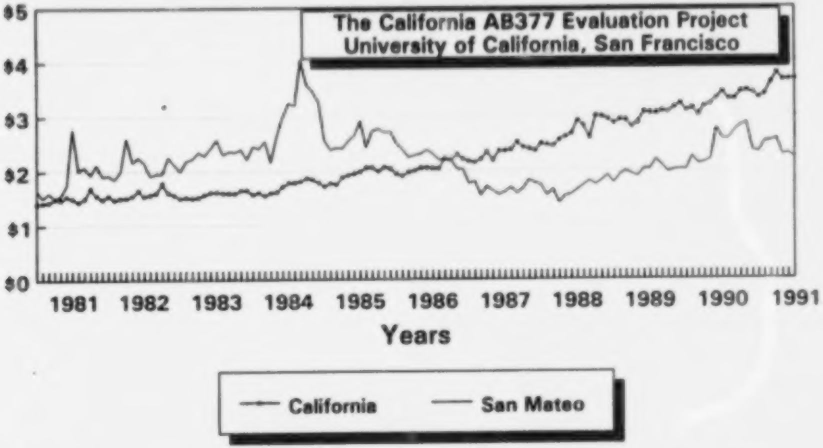
*based on the CPI, populations under 18
(cariinf.cht)

Source: Rosenblatt & Attkisson (1991)

FIGURE 1.2

State of California and San Mateo County AFDC-FC Group Home Expenditures

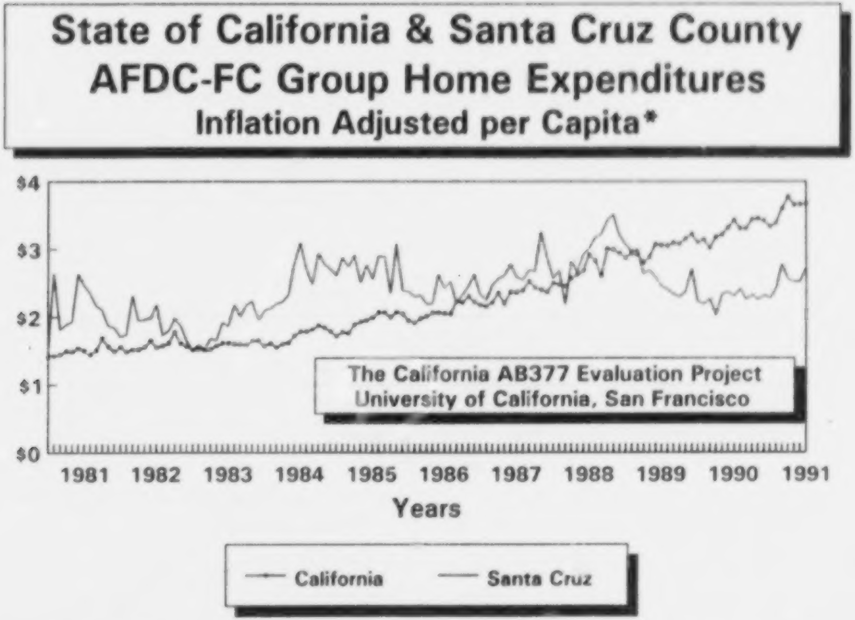
Inflation Adjusted per Capita*



*based on the CPI, populations under 18
(casminf.cht)

Source: Rosenblatt & Attkisson (1991)

FIGURE 1.1



State of California & Santa Cruz County
AFDC-FC Group Home Expenditures
Inflation Adjusted per Capita*

*based on the CPI, populations under 18
(cascinf.cht)

Source: Rosenblatt & Attkisson (1991)

Chairwoman **Schroeder**. Thank you very much. I appreciate it. You are talking about incentives. So often from the other level they want to call them mandates, but you are right. It depends on how you frame it.

Dixie Jordan, again, we thank you. We know it has been a difficult weekend for you, and we are very, very pleased to have you here. The floor is yours.

STATEMENT OF DIXIE JORDAN, PARENT AND ADVOCATE, PARENT ADVOCACY COALITION FOR EDUCATIONAL RIGHTS [PACER CENTER], MINNEAPOLIS, MN

Ms. **Jordan**. I am very grateful to have the opportunity to be here.

My son is now 18 years old, and Tom was different from the day he was born. I come from and am part of what I consider to be a very well family. However, he has an intrinsic disability that has led to different perceptions of how the world functions and how he operates within that world.

Tom's current diagnoses range from depression and anxiety disorder down through attention deficit, hyperactivity disorder. What I have learned about the field of psychiatry is that there are as many diagnoses as there are psychiatrists, which is really problematic in addressing the needs holistically of these children.

I also would like to be very clear about whom I am talking about. We have talked about a variety of social ills today, and I have heard many words given to the profound needs of children, all of which I would agree with completely.

However, in spite of the fact that we are also dealing with serious social issues, homelessness, lack of proper nutrition, and parenting skills that need to be improved, we are also dealing with children who, given the best of circumstances, would have an emotional disorder, a relational disorder to the world, and I want to focus specifically on those kids.

I also need to say up front that I find "biologically based mental illness" as a descriptor for children to be problematic. I think we have to look at contextually where children live and what they do, and not automatically interpret that a behavior is an illness without taking into the context the origin of that behavior, how it came into being. So I want to be really careful about that.

I came to this job (as a parent advocate) with absolutely no skills other than having a child with a serious emotional disorder. I learned, first of all, that education, if it is, in fact, a mandate, is a forgotten mandate. I learned that in order to access services through special education under the label "seriously emotionally disturbed" that one must be adamant about the needs of children and unceasing in the flagging of school personnel who do turn down those children, not because education does not understand the needs, not because they do not have the skills to recognize when a child is seriously emotionally in trouble, but because they are the payors of last resort. If there is a mandate to serve children with mental health needs in this country, I do not know about it.

Because children go to school, and that is the contextual environment for their lives, I would suggest that mental health services need to be adjunctive services to education. The parents I work with have children who go to school. Many of those parents do not have cars and thus do not have access to after-school mental health center care. Even if they had an automobile, they cannot get a babysitter to watch their other children; them may be single; they may have to work, they would not have access to after school counseling or evening services.

And so when I envision a mental health system, a community-based care system, I really envision mental health and education holding hands and doing this together, because I do not think it will work otherwise.

We need to remember that kids live in families and are involved with parents. I am working with parents who are getting divorced because it is the only way they can qualify their children for medical assistance to provide the services they so urgently need.

What kind of a system are we building where sacrificing families is the imperative to serving children?

I am here because I am really angry. I am angry because I have been an advocate for six years; four years ago I went to the Minnesota legislature and said, "We have to have a (children's mental health) law," and now we have a law, but nobody told me you had to fund it for services to be available.

I am angry because I kept holding their hands and saying, "It is okay. Tomorrow will be better," to those parents who called. Two of their children are dead. One is in prison for murder. Others are living on the streets, in gangs and with divorced families. I am telling you this was all wholly unnecessary.

The parents I speak with say, "We need respite care. I need to get away from my child for one hour, just an hour, just to watch television or take a walk down the street." That is not available.

The parents I talk to say, "If somebody would only come into our homes and show us how to manage the behaviors of these children, we would not have these problems." No one is there to do that.

But someone is always there to place a child in a hospital or an institution. They are always there if you can go to the systems and say, "I am a bad parent. Help my child."

Being Native American, I can tell you that American Indian kids are placed out of home at phenomenal rates, in white families to "socialize" and "educate" them; we are all "emotionally disturbed," by someone's criteria.

We are headed for a nation of jailers and jails, and as long as we continue to attribute behavior to mental illnesses without recognizing what has happened to kids and families growing up and the dilemmas and accessing services, we are making a terrible, terrible mistake.

I spend a great deal of time working with parents who are minority parents, and I think there is a serious concern. Kids are either over-identified based upon cultural attributes or they are under-identified, or not identified.

Indian kids who do not make eye contact are called depressed. Black kids who interrupt are called emotionally disturbed and conduct disordered. I wonder how many people who develop the systems, who write the psychiatric manuals, who apply diagnoses, have any concept of how it feels to grow up in a society that is truly racial, or what adaptive behaviors to that social reality might be.

I am deeply troubled by the classification systems which are, in fact, necessary and which are, in fact, valid in identifying mental health needs. I wonder how many of those were developed on the premise that you can expect behavioral differences from cultural differences.

I grew up in a family of 15 children, and my family contained an array of behavioral differences. Those differences were accommodated within the family unit. I think we have lost the capacity to recognize that differences, intrinsic differences, are good and can be contributory to the growth of a society and of a nation.

I believe that without putting maladaptive behaviors in an appropriate racial context, we are continuing to serve children poorly. I believe that the preponderance of out-of-home placements are with minority children in our country, and I do not believe that the supports are being provided to the families that need them.

So, in fact, when many of us come to you for help, we look "crazy." We look "dysfunctional," but we are at our wit's end in terms of needing help and having asked for it for so many years.

I talked with a parent once who was a "middle income" parent. Her family earned $26,500 a year. Her husband worked, and she stayed home with two children. Her son was in elementary school, and she called, desperate, and said, "I really need help. I have called my county, and they said we do not qualify for medical assistance. I called the state, and they said 'you have to go back to your county.' "

So she was in this terrible bind of not being able to afford basic counseling services for a child because their income went to pay for a home and a used car. The young man, who was six years old, threw his baby sister, who was 11 months old, down a flight of stairs.

After that, there was someone from the county coming into the house saying, "We are going to file neglect charges on you, because you are not properly monitoring your children."

No services were provided. The boy eventually cut one of his sister's eyes out with a pair of scissors. Then services were provided. This, folks, is wrong. It has to change.

I thank you very much for your time.

[Prepared statement of Dixie Jordan follows:]

Prepared Statement of Dixie Jordan, Parent and Advocate, Parent Advocacy Coalition for Educational Rights [PACER Center], Minneapolis, MN

My name is Dixie Jordan. I am the parent of a child—actually he's eighteen, and would likely not appreciate the categorization, who has such diverse diagnoses as depression, attention-deficit hyperactivity disorder, anxiety disorder, and specific learning disabilities. I work as an advocate at PACER Center in Minneapolis, a statewide parent training and information center for parents of children with disabilities, founded on the concept of Parents Helping Parents. At PACER, I coordinate a special project for parents of children with emotional or behavioral disorders. It is in that capacity that I would like to speak to you today.

When I first began working at PACER seven years ago, we received perhaps one call per day, if that, from parents who identified themselves as having children with emotional disorders. Today, the majority of our advocacy calls are from such parents.

We believe it should be the right of every parent to be able to tuck their child into bed each night, and to let their child know, before turning out the lights, that he or she is loved. Other parents have that choice, even if their child has a severe physical disorder or chronic health problem. For many of us, however, the choice exists between denying a child needed mental health treatment, because those services are simply not available in the communities where parents live, or "sending" the child to a hospital or institutional setting for treatment, recognizing that the psychic trauma from separation from family and familiar surroundings may be more damaging than the original problem.

We believe that to *serve children and youth with emotional disorders effectively,* that services MUST reflect the context of their lives and acknowledge that the least restrictive environment for this age group is their family homes, their schools, their communities.

As Congress focuses attention to the mental health needs of America's children, let us not forget that children live in families. I am currently involved with three families where the only way they can afford the limited and restricted services their children so urgently need is through divorce. In other words, to save a child may mean to sacrifice a family. Yet we spend many words describing the necessity of families to healthy children. We now need to develop policies which respect the honor and integrity of families, and which support, through services, their critical roles.

I have a particular concern for appropriate mental health services to be delivered in a child's normative daily environment, the public schools. A children's mental health agenda which addresses the emotional, social and relational needs of children must provide services where those needs are most frequently expressed. For most children, that environment is the school environment.

Educators are very good at recognizing children who may be in trouble emotionally. Educators know the severity of the problem. They also know that education is not adequately funded to provide urgently needed counseling and support to children. If children with serious emotional disorders are identified by school professionals as in need of services, schools may become the responsible service providers. Children, therefore, are not identified.

Many parents in America today, especially those living in inner-city neighborhoods, may not have transportation to a mental health clinic for their child. Or, they may have other children to care for which does not allow time to keep appointments with therapists working with their child. If such services could be provided by mental health professionals to children in schools as part of their special education curriculum, children would benefit tremendously. They could be taught new skills in the environment in which those skills are urgently needed, and not separated from peers, families, communities.

I have one additional concern that I believe must be addressed. Children who are ethnically, linguistically, culturally or racially different from the dominant society in America are frequently either underidentified or overidentified as having a serious emotional disorder based on those very differences. For instance, in Minnesota, Native American children are overrepresented, in proportion to their numbers in the general population, in special education programs for the emotionally or behaviorally disordered at 300%; African American youth are overrepresented at 400%.

While much lip service is given to "culturally appropriate services," I would be most surprised to learn that very many people know what that means. Developing a clinical diagnostic system to label illnesses serves an important function, especially to the insurance companies who may be required to pay claims only under specific categories of "illness". I am deeply troubled, however, that such classification systems have not been designed to address ethnocultural differences in diagnosis, to any substantive degree. It is simply not possible for a person who has not experienced racism first hand, for instance, to truly understand a child whose social behaviors were shaped by racial attitudes. To label behaviors as "deviant" without placing them in an appropriate racial context has led to the creation of a system where "mouthy" children are identified as conduct disordered, and "quiet" or acquiescent children may be identified as depressed. Family and community involvement in "setting the context" is critical if minority children are to receive appropriate diagnoses and services.

We hope that as the nation considers improvements in services for children with serious emotional disorders, close attention will be paid to a partnership effort. New legislation must provide ways to involve parents as active participants in their child's healing or treatment process. Only programs that nurture and build upon a family's existing strengths will succeed in the long run.

Chairwoman SCHROEDER. Thank you.
Dr. Rekers.

STATEMENT OF GEORGE A. REKERS, PH.D., PROFESSOR OF NEUROPSYCHIATRY AND BEHAVIORAL SCIENCE, CHAIRMAN, FACULTY IN PSYCHOLOGY, UNIVERSITY OF SOUTH CAROLINA, SCHOOL OF MEDICINE, COLUMBIA, SC

Dr. REKERS. As a professor at USC Medical School, I am involved in training clinical psychologists and psychiatry residents, I work in a teaching hospital funded by the State Department of Mental Health, I am a consultant to a private hospital that hospitalizes children and adolescents, and I am a peer reviewer for CHAMPUS and Blue Cross/Blue Shield. So I see these problems from several different angles.

This hearing focuses on the premise that there are tremendous shortages in community-based mental health services for children, and I think before we decide what should be done to address this national problem that the U.S. Congress should step back and ask the more basic question: "Why do we have these shortages of children's mental health services close to their home?"

As a research scholar, I have published many treatment studies, I have had many federal research grants from NIMH, and I can tell you that the basic causes of the shortages in services for children would be this if you think about it historically. Even though the mental health professions were developed and became a significant social force in the last 80 years of human history, at the same time the numbers of children and the percentage of our child population that need services, has outpaced even the rapid growth of these mental health professions.

The facts should logically lead us to ask a second critical question before jumping to any legislative action, and that is: what has caused the rapid growth in the percentage of U.S. children with serious emotional disturbances?

Now, I agree with Dixie Jordan that there are children with genetic conditions, organic mental disorders. There are children with disorders due to substance abuse of the parent or by the child or adolescent. But even though organic mental disorders and the substance abuse induced disorders, have been on the increase in recent decades, it is really the nonorganic mental disorders that have escalated to the greatest extent in children and adolescents.

And the research indicates that the fundamental cause for this is the family fragmentation that results in absence of accessible parents. This is often due to divorce, marital separation, unwed parenthood, sometimes death of a parent, and sometimes to unbridled careerism by one or both parents.

This hearing, which has the title "Close to Home" also needs to ask the question, "Who is at home?" which I think Mr. Wolf addressed. And as Dixie Jordan brought up, "Who is helping the parents in their home to provide the emotional climate necessary for the adjustment of their children?"

The continuity of affectional attachment and bonding, upon which so much of child emotional adjustment depends, has been disrupted for a rapidly increasing number of American children. This hearing has addressed ten million children with emotional problems in this nation, an increase in teen pregnancy, school dropouts, increase in suicide, substance abuse, physical and sexual abuse, but I think you would agree that it would be a sick and corrupt society which can only be stirred to action by such consequences and then fails to address the underlying fundamental problems.

Recently I published a review of this book called "Children in Family Contexts." The subtitle is "Perspectives in Treatment," by Lee Combrick Graham, and she demonstrated in this book that the family is the child's primary resource system, and that many professionals in education, child welfare, and child mental health have failed to recognize this fact in developing treatment programs.

If we take a historical perspective, we have to realize that 50 years ago in the United States we did not have the level of family fragmentation, the number of single parent families, and the level of parental inaccessibility that we have today. Neither did we have the critical shortage of mental health services and the need for substantial mental health professionals for children, and severe childhood emotional disorders were much more rare.

And if our society spends millions of dollars making computers user-friendly, why can't we as a nation achieve the goal of making more families child-friendly again, as we were five decades ago?

Before this Congress is the bill H.R. 1197 that proposes what I consider a symptomatic approach of massive treatment of emotionally disturbed children without a significant prevention component and without the necessary evaluation research.

The escalating percentage of children with severe emotional disturbance is symptomatic of some serious deficits in American culture, which then result in family dysfunction. There is an obvious need for prevention on a national scale, and in this, I agree with the Governor of Virginia, Douglas Wilder.

However, we need to remember that many of the sponsoring organizations of H.R. 1197 would expect to benefit by an exclusively symptomatic approach, and frankly, the special interest groups might suffer financial loss if prevention were the major component and prevention actually worked, decreasing needs for mental health services, including decreasing needs for psychiatric hospitalization. That is part of the professional turf issues Governor Wilder spoke of.

So unless we as a nation address the underlying value crises, the spiritual vacuum underlying family dysfunction that causes the serious nonorganic mental disorders in children, then the percentages of American children suffering severe emotional disturbance will continue to outstrip the capacity to fund and to staff mental health services that are needed, but at the same time will be indefinitely benefitting the mental health professions by creating mental health clientele.

Taking a symptomatic approach by itself will create just a perpetuation of these problems over the generations. We have to be careful. I think we need to recognize the failures of past welfare services that have caused, for example, the necessity for fathers to leave the family in order to get welfare benefits for their children. We need to watch out for things along those lines.

I agree with Governor Wilder that federal funds need to be redirected to early identification and preventative efforts. This is strategically important, and this has been dramatically illustrated by Dixie Jordan's testimony here.

Any legislation that would merely fund increased, even community-based mental health services would be short-sighted and only a bandaid approach. The suffering children in our nation certainly need more treatment, and they need more treatment closer to their homes. But even more urgent is the need for prevention efforts to stem the tide of the escalating numbers of emotionally disturbed children.

By analogy, it is only humane to feed, house and protect the Kurdish refugees from Iraq, but the U.S. State Department, I think we would all agree, would be very foolish and blind if it restricted its efforts exclusively to that symptomatic problem. Indeed, the larger and more fundamental task that President Bush and Secretary Baker are pursuing is a more comprehensive peace in the Middle East to end or at least reduce the number of conflicts that produce the hungry and homeless refugees.

Similarly, we need to aggressively pursue peace for the American family to greatly reduce the extent of marital conflict and parental inaccessibility that produces the emotional famine for so many American children.

[Prepared statement of George A. Rekers, Ph.D., follows:]

PREPARED STATEMENT OF GEORGE A. REKERS, PH.D., PROFESSOR, DEPARTMENT OF NEUROPSYCHIATRY AND BEHAVIORAL SCIENCE, CHAIRMAN, FACULTY IS PSYCHOLOGY, UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE, COLUMBIA, SC

As a professor at the University of South Carolina School of Medicine, I participate in training clinical psychologists and psychiatry residents and as a practicing clinical psychologist in the teaching hospital -- Hall Psychiatric Institute, I deliver clinical services to children and adolescents and their families in the State Department of Mental Health system; I also serve as a consulting psychologist conducting psychological evaluations at a private psychiatric hospital and I serve as a peer reviewer for both CHAMPUS as well as Blue Cross and Blue Shield.

Cause of Shortages of Mental Health Services for Children

This hearing focuses on the premise that there are tremendous shortages of community-based mental health services for children. Before deciding what should be done to address this national problem, the US Congress should step back and ask the basic question: "Why do we have these shortages of children's mental health services close to their homes?"

As a research scholar in the treatment of childhood mental disorders having received numerous grants from the US Department of Health and Human Services, I can tell you that the basic cause of the shortages in community-based mental health services for children is this: Even though the mental health professions developed as significant social services only in the past 80 years of world history and even though the numbers of mental health professionals has mushroomed to constitute a significant number to serve the US population only in the past three decades, the percentage of US children with serious emotional disturbances has significantly outpaced even the rapid growth in numbers of mental health professionals in recent decades.

Causes for Increase in Percentage of Children with Mental Health Disorders

These facts should logically force the US Congress to ask a second critical question before jumping to any legislative actions: "What has caused the rapid growth in the percentage of US children with serious emotional disturbances?"

The organic mental disorders -- for example genetically caused conditions or substance abuse induced mental disorders -- have not been the major factor in this rapid increase, although substance abuse by parents and by children/adolescents has significantly increased since 1950 and has produced increased numbers of organic mental disorders.

The non-organic mental disorders have escalated to the greatest extent in children and the research indicates that the most common fundamental cause is family fragmentation resulting in the absence of an accessible parent because of divorce, marital separation, death, or unbridled careerism by both parents. This hearing entitled "Close to Home" needs to ask, "Who is at home?" and "Who is helping parents be at home to provide the emotional support that children need?" The continuity of affectionate attachments with parents, which is so necessary for normal emotional adjustment, has been disrupted for a rapidly increasing number of American children.

This hearing has made reference to 10,000,000 children in the US with emotional problems; it has also cited the increase in teen pregnancy, school dropouts, teen suicide, substance abuse, and physical and sexual abuse of children. But I think that you would agree that it is a sick and corrupt society which can only be stirred to action by consequences and fails to address the underlying fundamental problems.

Eighty-eight percent of all Americans live in families and 50% of all families have children under the age of 18 years. (Chapman, 1985).

In 1960, one in 11 children in the United States lived in a single-parent home, but by 1990, one in four children were living in a single-parent home. Dr. Paul Glick of the United States Bureau of the Census, estimates that with the current divorce and remarriage rates, one in two--fully 50% of all children under age 18 in 1990--will have lived for some portion of their lives in a one-parent family. Ninety percent of these children live with their mothers, with their fathers absent from the home. In 1980, there were over 11,000,000 children living in families without a father-figure in the home.

In recent years, this committee has received testimony that has established the fact that single-parent families are forming at 20 times the rate of two-parent families. A record number of 1,200,000 divorces in 1981 affected 1,800,000 children. The divorce rate has more than doubled since 1970. But in addition, recent years have witnessed a notable increase in one-parent families in cases in which children live with a mother who has never been married. Since 1970, there has been a four-fold increase, to 2,800,000, in the number of children being raised by mothers who have never been married. These statistics, then, point to a major source of the new diversity existing in American families today as compared to previous generations--namely, the rapid increase in the total percentage of children living in father-absent homes.

To merely study the trends and demographics of family change does not, in itself, provide the full context necessary to understand normative family functioning or desired family functioning. For example, if a 51% majority of all fathers sexually abuse their daughters, this majority phenomena would not automatically be considered by our society to be desirable. It is imperative, therefore, that this Congressional committee differentiate diversity which arises out of family strengths from family diversity which arises out of weaknesses, problems and human failure. I will review a substantial body of empirical research which demonstrates that some types of families are inherently better environments for children's well-being.

To draw the analogy to physical health, we all know healthy people with a diversity of physical characteristics: there are short people, tall people, black people, white people, blue-eyed people, brown-eyed people and so forth. These are all fine variations which can exist in a healthy person. And so it is, there is a range of types of families within the normal functioning range which includes some families, for example, with

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a dozen biological children, others with two adopted children, and still other married couples with no children. Some families live near or with extended family relatives and some families live as nuclear family by itself. Some types of normal family diversity are build upon particular sets of strengths that a family may possess (Rekers, 1985a).

Extending our analogy to health, some people must unfortunately live out their lives with one part of their body chronically impaired or missing--an arm or a leg or an eye, etc. Such an individual has a physical handicap and perhaps through crutches for the person without a leg or by learning to use hearing more effectively for the blind person, the body can compensate for the loss of one of its normal members. And so it is with the family. Some forms of diversity are not necessarily desirable, for example, families with a physically abusive father, families who have lost a member through illness and death, families in which a father regularly gambles away his paycheck rather than providing support to the family, families in which children are neglected, or families in which drug abuse is chronic.

Research on Parental Accessibility and Child Mental Health

In a recent review of the cross-cultural research literature on parental accessibility by a Harvard professor, this conclusion was made: "Parents in this country (U.S.) spend less time with their children than in any other nation in the world, perhaps with the exception of England--the one country that surpasses the U.S. in violent crime and juvenile delinquency. Cross-cultural studies show that even in countries where children are brought up in collectives, parents tend to spend more time with their children than they do in this country. Research shows that, in Russia, fathers spend as much as two or three hours a day with their children. But, in this country, according to a study out of Boston, fathers spend on the average about 37 seconds a day with their young children" (Nicholi, 1985a).

Wide-spread parental inaccessibility and father absence in the U.S. is related to trends over the past 30 years in child-rearing practices, divorce, and out-of-wedlock birth rates. According to data from the National Center Health Statistics, between 1960 and 1980, out-of-wedlock birth rates rose from two to ten percent among whites and from twenty-two to fifty-five percent among blacks.

These facts should be of great national concern, because both developmental and clinical studies have well-established the general rule that *the father's positive presence in the home is, in the vast majority of cases, normally essential for existence of family strength and child adjustment*. A positive and continuous relationship to one's father has been found to be associated with a good self-concept, higher self-esteem, higher self-confidence and personal and social interactions, higher moral maturity, reduced rates of unwed teen pregnancy, greater internal control, and higher career aspirations (Alston & Nannette, 1982; Covell & Turnbull, 1982; Gispert, et al., 1984;

Lancaster & Richmond, 1983; Parish & Nunn, 1983; Romano & Micanti, 1983; Lewis, Newson & Newson, 1982; HOffman, 1981; Park, 1981; Russell, 1983). The overwhelming majority of the research studies indicates that fathers who are affectionate, nurturant, and actively involved in childrearing are more likely to have well adjusted children (Hetherington, 1965; Lamb, 1976; Pleck & Levin, 1986; Lewis, Feiring & Weintraub, 1981; Mussen & Distler, 1960; Park, 1981; Payne & Mussen, 1956; Radin & Russell, 1983; White, Woollett & Lyon, 1982).

Major child adjustment problems are associated with father absence or failures in fathering. With this huge exodus of so many fathers from the homes of American children over the past two decades, we should surely ask: "What is the effect of the father's absence on children's development?"

Research has documented that children without fathers more often have impaired psychological differentiation, deficits in social sensitivity, deficits in social role-taking skills, increased adjustment problems, a poor self-concept, low self-esteem, lowered self-confidence, less sense of mastery, less sense of mastery, less self-assertiveness, delayed emotional and social maturity, and greater internalization of morality and higher risks for psychosexual development problems (Alston & Nannette, 1982; Covell & Turnbull, 1982; Gispert, et al., 1984; Lancaster & Richmond, 1983; Parish & Nunn, 1983; Romano & Micanti, 1983; Lewis, Newson & Newson, 1982; HOffman, 1981; Park, 1981; Russell, 1983)

With major research grants from the National Institute of Mental Health for many years, I have studied psychosexual and gender disturbances in children beginning in 1972-1973 when I served as a Visiting Scholar at Harvard University. I have found that the father's absence is related to important risks for the boy's adjustments to a normal male identification (Rekers, 1978, 1985b, 1986; Rekers, Bentler, Rosen & Lovaas, 1977; Rekers & Jurich, 1983; Rekers & Mead, 1980; Rekers, Mead, Rosen & Brigham, 1983; Rekers, Rosen, Lovaas & Bentler, 1978).

Family studies research has isolated three major functions for an independently sustaining family unit with children--these are (1) income production, (2) household maintenance, and (3) child rearing. In the normal, intact family, these three functions are shared in a division of labor between the mother and the father.

When there is only one parent in the home instead of two, then one or more of these three vital functions usualy suffers serious loss unless there is massive outside social and/or economic support proided. Consequently, it is all too common that the children suffer economic, social and/or emotional deprivation. It is not surprizing, in this context, that low parental problems, deficits in social problem solving competencies, increased sexual promiscuity, susceptibility to peer groups involvement in delinquent behavior, drug and alcohol use, suicide, and homocide are all found to be higher among children from homes in which one or both parents are missing or

frequently absent (Brook, Whiteman & Gordon, 1985; Borduin, et al., 1985; Daum & Bieliauskas, 1983; Fry & Grover, 1982; Goldstein, 1984; Hoffman, 1961; Lewis Newson & Newson, 1982; Nicholi, 1985a, 1985b,; Parish & Nunn, 1983; Robin, 1979; Stern, Northman & Van Slyck, 1984).

Research has established that one of the more important functions that the father normally fulfills in the family is to ensure the development of appropriate sexual identity in his children (Biller, 1976; Drake & McDougall, 1977; Greenstein, 1966; Hetherington, 1966; Lynn, 1976). The absence of the father for boys has been linked to greater occurrences of effeminancy, higher dependence, less successful adult heterosexual adjustment, greater aggressiveness or exaggerated masculine behaviors (Apperson & McAdoo, 1968; Bene, 1965; Berg & Kelly, 1979; Bieber, 1962; Boyd & Marish, 1984; Earls, 1976; Evans, 1969; Greenstein, 1966; Mussen & Distler, 1960; Santrock, 1977; Stoller, 1969; West, 1959; Winch, 1949). All these detrimental effects reflect various reactions to an inadequate development of masculine role and male identification.

In girls, research studies by Heatherington and her colleagues have compared girls with two parents with girls who grew up without a father because of divorce or death of the father. Compared with girls with intact nuclear families, girls who lost their fathers by death were more inhibited in their relationships with males in general, but girls who lost their fathers by divorce were overly responsive to males, were more likely to be sexually involved with males in adolescence, married younger, were pregnant more often before marriage, and became divorced or separated from their eventual husbands more frequently (Hetherington, 1972; Hetherington, Cox & Cox, 1976, 1978, 1979; see Draughn & Waggenspack, 1986).

According to Cynthia Longfellow (1979), there are two crucial effects of father absence that need to be assessed in over 90% of the cases i which the father leaves: (1) the lack of parental supervision and discipline; (2) the lack of a sex-role model for the sons (Stoklasa, 1981). A number of research studies have found that single parents (usually mothers) are at risk to develop poor quality relationships with their children which can then lead to increased psychopathology among the children which can then lead to increased psychopathology among the children (Wallerstein & Kelly, 1975; Hetherington, 1972; Hetherington, Cox & Cox, 1976). Both unsatisfactory parent-child and parent-parent relationships are individual risk factors for psychiatric effects upon the children (see review by Larson, 1985).

Are the Effects of Divorce Positive or Negative for Children?

In a review of effects of divorce on children, Wallerstein and Kelly (1979), the investigators of the "Children of Divorce Project" of the Marin Community Mental Health Center in California concluded:

> Initially, almost all children and many adolescents experience divorce as painful and as disruptive of their

> lives, and their suffering is compounded by both unrealistic and realistic fears. These fears are related to the following factors: a heightened sense of vulnerability, sadness at the loss of the protected structure of the family and of the parent who does not retain custody, guilt over fantasized or actual misdeeds that may have contributed to parents' quarrels (although such fantasies are not found in all children), worry over distressed parents, anger at the parent or parents who have disrupted the child's world, shame regarding parents' behavior, a sense of being alone, and concern about being different from peers. For many children and adolescents, the overall initial response to divorce can properly be considered a reactive depression. There is no evidence that these initial reactions are muted or are experienced as less painful because of the high incidence of divorce taking place in the surrounding community.

Nevertheless, there have been statements in the professional literature, surprisingly, to the contrary. For instance, Michael Lamb (1977) concluded: "There is little support for the (assumption) that divorce is necessarily harmful....(p. 163)." Although he concluded that children of divorced parents are "at risk" for psychological damage, he also offered the opinion: "Divorce can be beneficial to children, inasmuch as it signals the termination of hostilities, uncertainties, and harmful hatefulness" (p. 171). Similarly, Phyllis McGrab (1978) acknowledged the sense of loss, the sense of failure, and the difficult transitions often associated with divorce for the child. But she also speculated, "When we consider the effect of divorce or separation on children, we must equally consider the effects of living in a home where there may be ongoing tension, conflict and stress. 'For the sake of the child' regardless of the short and long-term consequences, divorce or separation at times is the most viable solution to optimizing the potential of that child for sound emotional and personal growth." (p. 233).

Too often, in the professional literature, a supposed beneficial effect of divorce is presumed by making just this type of comparison: Compared to the conflict in a poor marriage, wouldn't the child be better off, after all, if the parents divorced? What is often omitted from the discussion is any potential for a third alternative for both the parents and the child: Namely, could the problems of the marriage be solved or resolved with some kind of help thereby eliminating the conflict and stress for the child. We must keep this third alternative in mind and not fatalistically assume that the divorce rate will continue at the present or higher rates, and that therefore somehow we must conclude that divorce is the best way out for many children. Too often, there is the assumption that nothing could be done to help solve the problem causing the conflict in the marriage.

Prior to the second half of the 20th century in America, divorce was not prevalent, and a popular attitude of even

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unhappily married couples was that they should stay together for the good of their children and to maintain the integrity of their marriage vow to remain together "for better or for worse until death due us part." In contrast, the latter half of the 20th century has witnessed a major shift in values to a popular lay and professional attitude expressing a strong sentiment that unhappy marriage for the couple is equally unhappy for the children, implying the needed so-called "solution" of divorce to restore happiness for the parents, which presumably will foster happiness for the children as well.

Although the myth of romantic love in marriage may be dying, the myth of romantic divorce flourishes for many Americans. While many might agree that perpetuating a conflict-filled marriage "for the sake of the children" only lacks emotional appeal,, I am increasingly disappointed by so many media reporters, professionals and married couples alike overlook the obvious third alternative to divorce or staying unhappily married--that is, it would be better to solve the marital problems and restore harmony in the existing marriage. With the widespread acceptance of divorce as a so-called "solution" to marital conflict, millions of divorce cases entering the courts in the last decade have never attempted concerted problem-solving efforts with an outside resource such as a marriage counselor, psychologist, clergy, social worker, or family life educator. Furthermore, the followup studies of Drs. Wallerstein and Kelly revealed that the majority (56%) of children surveyed five years after their parent's divorce did not consider their after-divorce family to be an improvement over their before-divorce home. The children reported more happiness before divorce than did their parents. The children generally prefer living together with both mom and dad. While neither an unhappy marriage nor divorce is the most desirable environment for children's development, too many professionals and lay people alike hastily assume the inevitability of continued unhappiness in the conflicted marriage to ethically justify the supposed "solution" of family divorce. Actually, most divorces are nothing more than trading one set of problems for a different set of tragic and often enduring problems--often including the problems associated with father absence. How much better it would be if the professionals and public alike refocused upon the search for a genuine solution to the marital dissatisfaction in order to preserve the family unit in an unbroken state.

The Third Alternative--Strengthening Marriage and Family Relationships

Furthermore, the followup studies on divorced children of Drs. Wallerstein and Kelly (1974, 1975, 1979) reveal that the majority (56%) of children surveyed five years after their parents' divorce did not consider their after-divorce families to b4e an improvement over their before-divorce home The children reported more happiness before divorce than did their parents. The children generally prefer living with both mom and dad, even in the presence of considerable conflict. From the child's perspective, divorce should be viewed as an extreme measure of last resort, something akin to the amputation of a limb if one's body is affected by gangrene and no medical treatment has succeeded, but only after trying all possible types of medical treatment.

While neither an unhappy marriage nor a divorce is the most desirable environment for children's development, too many professionals and lay people alike hastily assume the inevitability of continued unhappiness in the conflicted marriage to ethically justify the supposed solution of family divorce.

Actually, divorce is typically little more than trading one set of problems for a different set of tragic and often enduring problems, often including the problems associated with father absence. It seems that millions of parents have purchased their own relief from marital conflict with a divorce that forces their children to pay the price in unhappiness, stress, and adjustment problems that could persist for a lifetime.

Victimless divorce is either rare or nonexistent when children are present (Bane, 1979; Hetherington, 1972; Hetherington, Cox & Cox, 1978; Kelly & Berg, 1978; Reinhard, 1977). How much better it would be if the professions and the public alike refocused upon a search for a genuine solution to marital dissatisfaction in order to preserve the family unit in an unbroken state. Vast numbers of marriages could be strengthened and problem-solving methods are available to reduce marital conflict and distress.

Divorce has become one of the most common tragic crises in present day American society. The rapid growth of the number of broken homes has forced unprecedented numbers of children to suffer as innocent victims.

The primary cause of father absence in the American families today is divorce. Research on the effects of divorce reveals that the initial impact of the separation or divorce causes pain, suffering, fears and disruption for almost all children and teenagers involved (Bane, 1979; Berg & Kelly, 1979; Hetherington, Cox & Cox, 1976, 1978, 1979; Kelly & Berg, 1978; Kurkek & Siesky, 1979; Luepwitz, 1979; McDermott, 1968; Raschke & Raschke, 1979; Reinhard, 1977; Rutter, 1971). As a practicing clinical psychologist and family therapist, I regularly witness what the research documents for these children of divorced homes: these youngsters typically suffer depression over their loss, worry and anxiety over the marital disintegration, anger toward a parent for the resultant chaos and disruption, guilt over their real or imagined misbehavior thought to have contributed to the family break-up, loneliness and apprehensiveness over being seen as different from playmates, and a keen feeling of vulnerability to uncontrollable tragedy. The child's acute psychological distress and sense of family instability persists two or more years, with potential life-time consequences (see various studies by Wallerstein). Each year over the past decade, more than 1,000,000 under 18 years of age have experienced their parent's divorce, with estimates that between 32% to 46% of children who have grown up in the United States during the 1970's will have experienced separation or divorce of their parents. These wide spread effects are ot only psychological but also economic, with over half of all single-parent families living below the poverty level.

As the research strategies have become more sophisticated over time, the focus of studies on the father's impact on child development has shifted from comparisons of effects of fathers' absence versus fathers' presence to studies of the paternal characteristics which are associated with healthy adjustment (Franz, McClelland & Weinberger, 1991).

Dr. Armand Nicholi, a psychiatrist on the faculty of Harvard University, has expressed the widely held conclusion among scholars of child development research, "If we know anything about normal human development, it rests heaily on a close, warm, sustained relationship with both parents. And if people with severe emotional non-organic disorders have anything in common, it's that they have experienced, sometime in their childhood, an absence of an accessible parent because of death, divorce or a time-demanding job.

"Some people say, 'Well, it's not the quantity of time, it's the quality.' They use that statement to rationalize their not spending enough time with their spouses and children, but time is like oxygen. There's a minimum amount that is needed to survive. Less than that amount may cause permanent damage. And I think the same holds true for a child's time and exposure to both parents" (Nicholi, 1985a).

The research suggests a complex interaction between the father's dominance, paternal nurturance and his limit-setting which in combination promote normal child development and adjustment (Biller, 1976; Lamb, 1976).

The Family and Fundamental Problems

The fundamental problem sometimes involves lack of awareness on the part of parents of what children need emotionally but often involves parental irresponsibility and selfishness when parents fail to provide the kind of home environment that they know children need. Where parents are guilty of neglect and abuse of children, they need to be confronted with that reality and need to be encouraged to provide for their children. They do not need to be cast in a victim role and excused of their responsibility and offered rationalities for their guilt.

I recently published an invited review in the journal entitled Medical Psychotherapy of the book, Children in Family Contexts: Perspectives on Treatment by Dr. Lee Combrinck-Graham who demonstrated how the family is the child's primary resource system, but many professionals in education, child welfare, and child mental health fail to recognize this in their professional work. Fifty years ago in the US, we did not have any where near the level of unwed mothers, one parent families and the parental inaccessibility that we have today and neither did we have a critical national need for substantial mental health services for children because the severe emotional disorders were at that time relatively rare. If our society spends millions of dollars making computers "user friendly," why can't we as a nation achieve the goal of helping more families become "child friendly" again?

The Symptomatic Approach of H.R. 1197

Before this Congress is the Bill, H.R. 1197 which proposes a symptomatic approach of massive treatment services for emotionally disturbed children. Without any significant preventative component and with inadequate attention given to independent evaluation research to demonstrate the effectiveness of these treatment interventions.

The Central Necessity of Prevention

United States Senator Dan Coats was previously the ranking minority member of the Select Committee for Children, Youth, and Families in the United States House of Representatives. As part of his work on that committee, he visited a juvenile detention facility in Santa Ana, California. This facility, considered one of the most modern in the country, was designed on the basis of the latest research. Huge sums of money are spent yearly on staff salaries and operating costs. Yet Congressman Coates described his review of that facility in these words:

> About fifty young people were incarcerated there and participating in the program. While there, we had time to speak individually with the counselors and the children. I came away with almost a sense of despair because here we had the very best facilities that money could buy, the best of techniques, yet there didn't seem to be any progress. There didn't seem to be any hope present in the lives of the people we spoke with.
>
> As I talked to one of the counselors afterward, I said, "You have kids here with delinquent behavior, drug, drinking and sex problems, and all the other problems that are common to young people today. If you could boil all this down, what is the common cause? What is the lowest common denominator? What is the one reason these kids are in this place?"
>
> He very quickly replied, "Well, I've been involved in this work for twenty-five years and I've spent a lot of time asking that same question. The one common denominator is that every one of these kids in this facility is from what I would call a disoriented family. There is something present in the family that is out of sync. It is not what we would call normal - if there is something such as a normal family. The kids here who are violent have been subject to violence in their families. The kids here who are on drugs or drinking have seen drug abuse in their family. We see this cycle being repeated and repeated."

Every family counselor knows the devastating effect that problem families can have on adults and children alike. Professor Nick Stinnett, one of the leading researchers in the area of family strengths, pinpointed the key issue: "Many of our major social problems - juvenile delinquency, child abuse, spouse

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abuse, elder abuse, some forms of mental illness - can be linked very closely to bad quality of family life, that is, to the absence of family strengths. I think each of us knows deep inside that so much of our happiness, so much of our emotional well-being depends or is influenced to a great degree by the quality of the human relationships we have, and particularly by the quality of those intimate relationships we call family relationships. So promoting family strengths should be one of our country's top priorities" (Stinnett, 1985).

Twenty five years have passed since Dr. Gerald Caplan published his PRINCIPLES OF PREVENTIVE PSYCHIATRY. The book was a pioneering work that gave the first systematic presentation of the rationale and methods of preventive psychiatry and community mental health (see Collins, 1985).

Caplan's book presented what others have called the "upstream approach to helping." Assume that a person is walking alongside a river and sees a child drowning. Quickly, the observer jumps into the river, pulls the victim out and begins artificial respiration. While this is going on, another person calls for help and is rescued. This is repeated several times and soon a whole group of rescuers is busy pulling people from the river and trying to give help.

Eventually, a couple of the rescuers get up and hurry away from the scene. "We're going upstream," they announce. "We want to find out who is pushing these people into the river and see if we can stop it!"

The story is simplistic perhaps, but it illustrates the approach that we, as a society, have taken to meeting human needs. Many years ago, the medical profession began to focus on the prevention of problems-the upstream approach. But we in the mental health fields, including marriage counseling and family therapy, have tended to remain downstream, investing enormous amounts of time, effort and money in rescuing the people who have developed severe problems in personal and family living. Then we send these people back to the source of their original problem and wonder why they sometimes have to be rescued again-and again.

Of course, there are good reasons for this emphasis on the downstream approach (see Collins, 1985). As long as people need to be rescued, there is little time or opportunity to think about prevention. Government agencies, charitable foundations, insurance companies and other funding sources want to help rescue the perishing and care for the dying. This is where we can see both the needs and the results of our efforts. Prevention is less exciting, less dramatic and sometimes less obvious as a way of giving help. Limited resources go to downstream efforts and the problems are rarely tackled upstream.

Prevention upstream is not easy. If we consider the problems of families, for example, it is difficult to know where and how to design clear and valid preventive approaches.

To a large extent, the problem arises because there is not just one cause of family tension; there are multiple causes (Collins, 1985). Egan and Cowan have demonstrated this in their interpretation of the systems approach to helping. The individual is influenced by the peer group, work place, classroom and family. All of these are affected by social institutions-such as the government, the mass media and the educational system-and all of this, in turn, is set within cultural folkways and mores.

To prevent problems from developing in the individual and in the family, there must be broad community efforts. Dr. Caplan made this point on the first page of his book. Henceforth, he wrote, "the prevention, treatment and rehabilitation of the mentally ill and the mentally retarded are to be considered a *community* responsibility and not a private problem to be dealt with by individuals and their families."

Any program of prevention must ask at least three basic questions.

A. What Type of Prevention Will We Emphasize?

According to Caplan, prevention can be of three kinds. *Primary prevention* helps people avoid problems before they even get started. *Secondary prevention* attempts to stop developing problems from getting worse. *Tertiary prevention* attempts to rehabilitate people after they have recovered, for example, from a problem marriage.

Primary prevention tries to help couples avoid major marital problems. Secondary prevention takes marriages that are beginning to develop problems and stops these from getting worse. Tertiary prevention could involve work with divorced people whose original marriages failed. The tertiary approach seeks to help these people learn from their earlier marriage problems and avoid similar mistakes in the future.

B. Who Will receive Our Preventive Interventions?

We can try to work with *entire populations* perhaps by working to enact laws that apply to everyone. We can focus on *milestone populations* - those who are at turning points in life such as the start of a marriage, the beginning of parenthood, the crises of middle age, the shift to a new career or the approach of retirement. Alternatively, we could focus attention on *high risk populations* such as the children of alcoholics, abused spouses, grieving mates, unemployed parents or the poor.

C. What Kinds of Programs Will We Develop?

Some preventive programs are *person centered*. Often individuals are given encouragement, warnings and specific help in anticipating and avoiding future problems. *Family centered* approaches, as the name implies, work with entire families. As an example, we could consider the many community efforts, In the United States, to help Asian refugees get settled in new homes and localities.

Since the publication of Caplan's book, most preventive programs have been *community centered*. The development of suicide prevention "hot lines," the establishment of community mental health centers or political efforts to reduce poverty are all examples.

If we are to consider ways of strengthening families and preventing family problems, some attention must be given to the above questions.

Normal development and adjustment depends upon the continuity of close, affectionate, nurturant bonding between parent and child. Armand Nicholi, M.D., psychiatrist on faculty of Harvard University: "If we know anything about normal human development, it's that it rests heavily on a close, warm, sustained relationship with both parents." (Nicholi, 1985). This was emphasized in the April 1991 issue of Journal of Personality & Social Psychology which reports findings of a 36-year study that links parental warmth, hugging, and cuddling to better mental health, work success, marital satisfaction and greater inner security (Franz, McClelland & Weinberger, 1991).

"Professional relationships can never give a person the kind of nurturance, the positive input that a close family relationship provides." (Nicholi, 1985).

The etiology of non-organic psychopathology frequently involves a history of dysfunctional family relationships and parental inaccessibility. "If people with severe emotional nonorganic disorders have anything in common, it's that they have experienced, sometime in their childhood, an absence of an accessible parent because of death, divorce or a time-demanding job." (Nicholi, 1985).

Substance abuse, suicide, homicide, homosexual orientation disturbance, delinquent behavior, unwed pregnancy, poor academic performance, and other behavioral problems are found in higher rates in children from homes in which one or both parents are missing or frequently absent.

Divorce has detrimental effects on children's emotional adjustment, both short-term and long-term (Judith Wallerstein's research). Intense loneliness, isolation and feelings of failure accompany divorce.

Since the 1960's in the USA, there has been a huge increase in the proportion of the population that use nonmedical drugs to change their mood, to avoid unpleasant feelings or in response to an inability to cope with stress. Dr. Nicholi points out that this development paralleled three trends in American family life:

a. Beginning several years before the onset of the rearing practices in the US which shifted child care from parents to other agencies.

b. Cross-cultural studies show that American parents spend less time with their children than parents of any other nation in the world, with the possible exception of England, the one country that surpasses the US in violent crime and juvenile delinquency.

c. The accelerating divorce rate quickly paralleled the rise in drug abuse. "Divorce has left more than half of all the children in the US under 18 years of age with one or both parents missing" for a portion of their childhood.

THE RESEARCH ON FAMILY STRENGTHS

A large number of quantitative and qualitative research studies on the characteristics of strong families have produced parallel results in recent decades. Some of these investigators are Otto, Whitaker, Hill, Lewis, Satis, Stinnet, Beavers, Gossett, Phillips, and Curran. An unpublished summary review of the research of these various investigators by Dr. Judson Swihart (at the Department of Human Development and Family Studies, Kansas State University) found that the five characteristics of strong families found in common throughout all these investigators' research were the following: (1) good communication between family members, (2) appreciation expressed for one another in the family, (3) a spiritual/religious commitment, (4) adaptability and flexibility in the family, and (5) clarity of family rules.

Certainly the family is the cradle of any culture. The family is a basic unit in society for nurturing human development. Dr. Nick Stinnett offered this insight:

> I would not dream of teaching someone how to play tennis by only telling them how *not* to do it: "Now you do *not* hold the racket this way. You do *not* do a back stroke this way." A coach would not succeed if he only made remarks like, "This is wrong, don't stand like this, this is terrible," while never telling the person how to stand right and how to hold the tennis racket correctly. But, unfortunately, to a large extent we have done that in the area of family life. For example, we've told people what the families of delinquents or runaways are like, and we've said, "Now, don't let your family be like that." We have not used the positive model approach. We have not said, "Here's what a strong family is like and your family can work on these positive qualities."

It is extremely useful and perhaps mandatory that every psychotherapist have clearly in mind a model of a well-functioning family. Studies published by a number of researchers in recent years now make it possible for us to report on the characteristics that strong, healthy, adaptive families have in common. For example, Dr. Stinnett and his colleagues studied over 3000 families who rated themselves very high in terms of marriage happiness and in terms of their satisfaction in parent-child relationships. Other people in the community endorsed these families as examples of healthy family functioning. After extensive study of these families through questionnaires, interviewing, and following protocol of data gathering, the researchers found that these families (from North America, South America, Switzerland, Austria, Germany, and South Africa) had six major qualities in common.

1. High degree of commitment to the family

Strong families are highly committed to one another and to their family group. Because commitment is often absent in families that seek counseling, the family counselor needs to be able to define this desirable quality so that the family can begin to grasp what it would mean to have a high degree of commitment to one another.

In strong families, family members are determined to promote each other's welfare and they know they have one another's support. This commitment is measured by the high priority they place on family issues and family life. As Stinnett points out, "Commitment is something that is essential to the success of any group - whether it's a football team, a business organization or a family."

A high level of family commitment typically begins in the married couple's relationship, where the husband and wife view their solemn vow of marriage as a lifelong commitment to one another "for better or worse."

Dr. Ted Ward, a professor emeritus from Michigan State University stated: "A conservative attitude toward divorce, usually a religious tenet, works toward upholding family commitment" (Ward, 1985).

As Professor Nicholi has pointed out, "Commitment involves many things. It involves the interrelationship between child and adult that is extremely complex. It involves identification of the child with the parent. It involves all kinds of interactions that we understand are necessary in order for the child to develop into a mature human being. But little of that complex process can take place unless the parent is physically and emotionally there, and unless the parent makes a commitment of time."

What starts out as a commitment to the marriage relationship therefore extends to a family commitment in the parent-child relationship after children are born or adopted. In family counseling, it is often necessary to help family members sort out their priorities and see what commitments of time and energy are superseding their commitment to the family.

2. Spend time together

Closely related to family commitment, the second major characteristic of a strong family is that they spend a great deal of time with one another. When researchers have asked people to identify the happiest memories they have of their family life during childhood, the majority of their reports represent examples of simply doing things together with family members. People recall trips to visit grandparents, working together on projects with the family, playing games with family members, Christmas celebrations with the family, and outdoor camping activities. The kinds of things people typically recall do not require large investments of money, but instead represent major investments in time. Strong families deliberately arrange to spend large amounts of time relating with one another. By contrast, so many problem families have only superficial contact with one another which does not allow for deep and effectual human relationships.

The family counselor is likely to encounter the rationalization, "It's not the quantity but the quality of time you spend with a person that is important." Psychiatrist Armand Nicholi has argued that this statement is designed to rationalize not spending enough time with one's spouse or children: "Time is like oxygen. There is a minimal amount that is needed to survive. Less than that amount may cause permanent damage. And I think the same holds true for a child's time and exposure to both parents.

"If we know anything about normal human development, it's that it rests heavily on a close, warm, sustained relationship with both parents." "And it takes quantity as well as quality to develop warm and caring relationships." Nicholi has observed that this principle can also be stated negatively: "The lack of time spent between parents and children is a primary cause for the increase in suicide and emotional disorders among children and youth in this country over the past few years."

Psychotherapists need to inform problem families that healthy family functioning requires large amounts of time committed to one another. Without this time for interaction, it is extremely difficult to resolve family problems.

3. Have good family communication

Strong families have been found to practice good communication. They are good listeners, and they are skilled in expressing their thoughts, desires and emotions to one another. This finding of good communication patterns in strong families is not at all surprising to the family counselor. Even so it is useful for the counselor to point out to families an observation made by Dr. Judson Swihart (1985), an experienced family counselor: "...strong families do not automatically have a good communication system. They have to desire it, work at it, reevaluate it and consistently maintain it. Communication requires a constant watchful eye and large doses of nurturing."

So often in problem families, the family counselor will observe harsh, condemning and critical parents who, although they may have the best of intentions, contribute to a harsh and insensitive communication pattern which is destructive to the family member's well-being.

Because good family communication patterns are hallmarks of adaptive, healthy families, a major goal for family counseling often involves enhancing relationship patterns and teaching families how to communicate with greater skill, effectiveness, and love.

Dr. Grace Ketterman (1985) has identified seven characteristics of good communication:

a. Communicators must have minds open and ready to focus on the present issue.

b. Communicators need to keep their intellects equal to or transcendent over their emotions.

c. Communicators will be more successful if they avoid being judgmental or condemning in their attitudes.

d. Communicators will be more successful if they learn to empathize with each other, but to avoid too much sympathy or pity.

e. Communicators do best when they listen with their hearts as well as their heads.

f. Communicators need to keep a clear focus on the goal of each transaction.

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g. Communicators need to find a satisfactory balance in the use of assertiveness and gracious deference.

4. Express appreciation

Strong families express a great deal of appreciation to each other; give each other many sincere compliments; make each other feel good about themselves; psychologically build up each other.

Dr. William James: "...one of the most important human needs of all...(is) the need to be appreciated."

Dr. Gary Collins: "appreciation, when expressed, becomes affirmation. If you take affirmation one step further, it becomes encouragement."

5. Have religious involvement together (spiritual wellness)

Many researchers have found that strong families have a high degree of religious orientation and commitment. Dr. Stinnett (1985) reported that these families typically state, "God has a purpose for our lives. God is a source of strength for my family and for me as an individual."

"Our awareness of God in our day-to-day life helps us to be less impatient with each other, helps us to get over anger more quickly and helps us to be more supportive and positive in our relationships with each other."

Spiritual values such as love, kindness, tolerance, and support tend to promote positive family relationships. Strong families usually go to church together, have family devotions at home, and encourage one another in their common faith. Researchers found that higher levels of religious involvement are associated with higher levels of satisfaction in marriage. Because a strong spiritual commitment is typically found as a characteristic of strong families, pastors are in a particularly advantageous position to serve as family counselors. Family therapists should encourage the positive spiritual growth and development of the families they are counseling as a primary goal.

All family therapists encounter families in which the individual members adhere to a variety of world views and are consumed with a variety of preoccupations. With the intensification of media influences on individuals and the diversity of programming in television, radio, and printed matter, we now have a situation in which no single mentality characterizes all dysfunctional families. Many poor families or families in the Third World may be primarily preoccupied by survival issues or by concerns for justice and political liberation. Middle-class North American families and many European families may be essentially pursuing various preoccupations related to the impoverished values of "personal peace and affluence" as Dr. Francis Schaeffer has labeled them. Different families as well as different individuals in the same family can be caught up with differing problems and preoccupations depending upon their individual beliefs and life circumstances.

In turn some of the family's life circumstances have been created by the immoral choices made by the family members. Other unfortunate life circumstances are a general result of other sources of problems. For example, some family members may suffer from the effects of alcoholism or drug abuse brought on by a sequence of deliberate choices by a family member. Children may suffer from the emotional deprivation resulting from a decision by a parent to divorce or from some other tragic circumstance. Victims of family violence suffer from the wrong choices made by the violent perpetrator. Individuals may experience depression and anxiety in response to a family member's chronic practice of sinning against them. Low self-esteem, insecurity, and financial struggles are often by-products of the sinful choices of family members. Because the family is such an intimate environment, the sin of one member can ultimately affect and trouble the relatives of the sinner.

Strong families usually go to church together, are involved in church activities, have family devotions and prayer.

Research on the relationship of religious affiliation to divorce rates found (see review by Larson, 1985):

a. When both spouses were Jewish, the divorce rate was 5.4% less than the total mean;

b. When both spouses were Catholic, the divorce rate was 3.8% less than the total mean;

c. When both spouses were Protestant, the divorce rate was 1.2% less than the total mean;

d. When one spouse was Catholic and one spouse was Protestant, there was a divorce rate 5.2% above the total mean;

e. When the wife was Protestant and the husband had an "other" religious denomination, the divorce rate was 12.2% above the mean;

f. Spouses with "no religious affiliation" had divorce rates similar or higher to those with "mixed marriages."

Married couples rating themselves as "very religious" have higher "barrier strengths" against divorce and have far lower prevalences of separation or divorce than there is among the less religious (Larson, 1985).

Empirical studies have supported the hypothesis that married people who attend church frequently are more satisfied with their marriages than those attending less frequently (see Larson's 1985 review).

Research by Berkman and Syme (1979) studied 2,200 men and 2,500 women at nine years after initial assessment, and found that the nonmarried males died younger than did the married males in all age groups; also male and female church members in all age categories lived longer than did nonchurch members.

Comstock and Partridge (1972) studied arteriosclerotic problems in the cardiovascular system--a leading cause of death and hospitalization in the US, and found religious involvement to be protective for arteriosclerotic disease: They found almost two times greater risk for mortality for both males and females who attended church less than weekly compared to weekly or greater church attenders.

Zuckerman, Kasl and Ostfeld (1984) conducted a case-controlled study of an elderly population and found that the less religious had mortality levels twice those of the more religious after a two year followup.

A family-studies professor at Kansas State University, Dr. Walter Schumm, has convincingly demonstrated how this characteristic of a strong spiritual commitment is the foundation for all the other qualities that make families strong. A spiritual commitment usually underlies commitment to family. And genuine commitment to family is translated in everyday living in terms of the amount of time families spend together. The strong spiritual commitment also motivates (1) the love family members have for one another, (2) spending time together, and (3) expressing appreciation for the family. The combination of those three factors provides the foundation for the development of a good communication pattern. A solid communication pattern combined with spending enough time with each other assures strong families they can then develop strong problem solving skills - which is the sixth major characteristic of strong families.

6. Solve problems and crises

Stinnett (1985) found that strong families experience crises like any other family but the distinctive feature they have is the reaction of consciously pulling together to cope with problems they encounter. Instead of letting a crisis or source of stress drive family members apart, the strong family deals with bad situations and stressful times in positive, constructive ways. Family members help one another and function as a support system.

William Wilson, MD, Emeritus Professor of Psychiatry, Duke University Medical School reported: "Effective crisis management in the family has these components:

a. The family has a realistic perspective of the event that does not view the crisis as more or less than it deserves;

b. The family has not cut itself off from adequate support structures;

c. The family effectively mobilizes resources and makes sacrifice when necessary;

d. The family has the ability to anticipate the future and reorganize to meet it; and

e. The strong family has a philosophy to live by that gives hope" (Wilson, 1985).

Wilson (1985) defined a crisis as a functionally debilitating state that results from an individual's reaction to some event perceived to be so dangerous that it leaves him or her feeling helpless and unable to cope effectively using usual methods.

Symptoms of an unresolved crisis: Tiredness and exhaustion, loss of sleep, a decrease in sex interest, feelings of inadequacy, uncertainty about the future, worry, sighing respirations, irritability, loss of interest and a feeling of being trapped. These symptoms are associated with most stress syndromes.

One-half of personal crises have origins in the family.

Joan Jackson has listed some of the factors that operate in a family's adjustment to the stress of alcoholism. She has diagrammed these to illustrate how they interact to produce family inadequacy and thus increased susceptibility to stressful events. The crisis develops because of the inadequacy.

The factors that contribute to the development of crisis are: (1) inadequate interpersonal relationships, (2) cultural diversity, (3) conflicting roles, (4) economic and other pressures, (5) class membership pressures and (6) unrealized aspirations. Professor William Wilson contends that Jackson's conceptualization is applicable to the development of all crises.

Types of crises that affect the family (classified):

a. *Dismemberment* (e.g., death of a loved one, hospitalization of a child or spouse, separation caused by war);

b. *Accession* of another family member (e.g., unwanted pregnancies, the return of a deserter, the addition of a step-parent, some war reunions, some adoptions, etc.);

c. *Demoralization* of the family (e.g., nonsupport, infidelity, alcoholism, drug addiction, delinquency, disgrace);

d. *Demoralization plus dismemberment or accession* (e.g., illegitimacy, runaways, desertion, divorce, imprisonment, suicide, homicide, institutionalization for mental disorder);

e. Stress from *status shifts* (e.g., sudden impoverishment, prolonged unemployment, sudden wealth and/or fame, refugee migrations from persecutions, disasters).

Degree of stress caused by types of crises:

a. Accession is the most stressful for family

b. Demoralization alone or in combination with dismemberment and accession ranks next in severity

c. Status shifts are least stressful

Several factors have been shown to give rise to harmonious family life that results in children of worth (Wilson, 1985):

a. The most critical is that husband and wife love each other;

b. There must be order in the home;

c. Roles must be well delineated, complementary and traditional;

d. Discipline should be just, not harsh;

e. Parents should subscribe to traditional values, live by them, and teach them to their children;

f. Parents should have a philosophy to live by that makes a favorable difference in their lives.

Dr. Stinnett's (1985) research found that strong families dealt with crises by:

a. Working together manually and/or discussing the problem among themselves;

b. Praying and having faith in God; putting their spiritual values into practice in working together;

c. Receiving comfort, encouragement and understanding from immediate family, relatives and friends (accomplished through phone calls, visits, cards, flowers, material help or manual aid).

The family counselor should encourage the family to identify deficits in these areas of family strength and to work toward increasing the qualities which promote family wellness.

The Tragic Neglect of Prevention

The escalating percentage of children with severe emotional disturbances is symptomatic of serious deficits in the American culture which result in family dysfunctions and divorce. There is an obvious need for major prevention efforts on a national scale which should accompany any new treatment initiatives. However, we need to remember that the sponsoring organizations to H.R. 1197 expect to benefit from an exclusive symptomatic approach and would expect losses to their special interests, if the prevention approach were widely applied and became successful. This is part of the professional turf issue that Gov. Wilder from Virginia testified about as the lead witness to this hearing. Unless we, as a nation, address the underlying value crises and moral vacuum underlying the family dysfunctions that cause serious non-organic mental disorders in children, the percentage of American children suffering severe emotional disturbances could continue to outstrip our capacity to fund and to staff mental health services needed, while at the same time indefinitely benefiting the members of the mental health professional associations sponsoring this legislation.

The Kind of Prevention Needed

Many serious marital and child development problems could be prevented or corrected in early stages if families were better equipped to recognize family strengths and to build upon those strengths. Many needy marriages would benefit from learning about the successful and coping practices used by families with high levels of well-being. There is a glaring need for more prevention and family life education to off-set the need for expanded governmental financial support for remedial social services for child victims of broken families. The escalating rate of increase in broken families might tax our natural resources to the limit if we fail to find solutions to mending marriages and strengthening existing families because of our preoccupation (such as we see in H.R. 1197) with the remedial task of providing services to the victims of broken families.

The Federal Role Proposed

The federal role needs to be reconceptualized to analyze family impact variables, to determine the impact of national policies, regulations, taxation and legislation upon families, and to publicize how successful marriage and family life works. Strategic funding should be appropriated to the Office for Families in the Department of Health and Human Services with the mandate to develop family life education materials based upon the values of the desirability of marital permanence, with sexual relationships reserved exclusively within marriage and the importance of the continuity of parental care for children. These materials could be provided to and disseminated by private, local community service organizations (including scouts, volunteer city service clubs, PTAs, churches, synagogues and social agencies). Marriage enrichment and parent education curricula that promote the moral values and skills possessed by strong American families should be identified, developed, evaluated and disseminated by the U.S. Office for Families to existing social support networks in local communities.

Research indicates that family connections with local support networks decreases demand for use of a variety of governmental social services. Research has established a high correlation between religious commitment and family commitment; this finding underscores the strategic importance of encouraging the work of religious institutions with family education and their involvement with natural helping networks for families. Volunteer resources can be activated by providing effective preventative educational materials for local programming to enhance marital satisfaction and parental competence, nurturance, and human problem-solving skills. By promoting dissemination and widespread utilization of demonstration project findings on building family strengths, the federal role could effectively facilitate private and local agency efforts to prevent family breakup, thereby promote more stable and adaptive child development, and thereby prevent much of the serious emotional disturbance experienced by American children.

Family and Life Education, Intergenerational Networks and Community Groups

Research with families (Stinnett, 1985) identified six characteristics of strong families:

1. Knew how to express appreciation to one another.
2. Knew how, and spent time together.
3. Had skills in family communication.
4. Had a high degree of commitment to the idea of family and to their own family.
5. Had a high degree of religious orientation.
6. Had the ability to deal with crisis in a positive manner.

These characteristics of strong families can be threatened by rapid social change. They can also be cultivated and enhanced by effective education, intergenerational networks, self-help groups, and cooperation between public and private organizations. There is need to communicate to families ways in which the characteristics of strong families are developed and expressed in families at different life-stages, e.g., families with young children, families with adolescents, families in middle years with grown children and frail elderly. Brammer and Abrego (1981) and Danish (1981) have emphasized that some families need help to prepare for and creatively move through the developmental transitions of the family life span. They stress that parenting and other life events can be anticipated and offer opportunities for enhancement through presenting models and skill building

> Family life (and parent) education programs communicate an expectant belief that each family unit has within it dormant capacities for coping with transitions. In spite of their

> coping capacities, many families get blocked at transition points by employing repetitive patterns that maintain the family system, resisting family adaption and development. Experimental (parent) education programs help families draw upon creative resources inside and outside of themselves to find new ways to 'develop through' difficult transitions. (Brammer and Abrego, pp. 19, 31).

The family is a social organism whose potential is sometimes uncultivated, or is only partially actualized, because its members--having grown up in it--do not recognize its identity, nature and purpose. Some may take it for granted, others may think its circumstances cannot change. The vitality of a social organism is dependent upon the care and attention its members give to its maintenance and well-being. That is, a social organism serves its members best as they in turn serve it (Yankelovich New Rules, 1981). We need to help families recognize the moral values that promote positive relationships and to recognize their family strengths and their roles as the integrating influence for their members. The Carnegie Council of Children (Keniston, 1979) pointed out that today's parents are frustrated by the great number of socializing institutions which seem to be directing the lives of their children.

Empowering Parents

"As a result, the parent today is usually a coordinator without a voice or authority...If parents are frustrated, it is no wonder; for although they have the responsibility for their children's lives, they hardly ever have the voice, the authority or the power to make others listen to them" (Keniston, 1977, 1, 18).

Keniston and others (White, 1979; Spock, 1980) emphasize that we need to provide proper guidance and encouragement for families to affirm and perform their role as the primary teaching and support institution. White declared that we need "to recognize that the first priority is to prepare and assist families as the child's first educational delivery system" (White, 1979, p. 193). Spock (1980) suggested that the proliferation of information about parenting has sometimes confused parents and caused them to lose confidence. Keniston (1977) stated "Americans today wonder whether they are doing a good job as parents, but are unable to define what a good job is. In droves they seek expert advice" (p. 2). Alison Clarke-Stewart (1978) estimated that 23,000,000 parenting and child-rearing primers had been bought in a five year period.

In October 1981, for the first time, the professional periodical, Family Relations: Journal of Applied Family and Child Studies devoted a special issue to Family Life Education. It underscored the fact that there is a growing body of information on family life and a growing interest in developing family education programs. However, there is a problem of getting the information to the families. Families do not have time and/or they sometimes encounter other logistic or psychological problems that keep them from attending special meetings for family education and consultation (Cromwell & Cromwell, 1980). Our strategies need to be improved for taking family education resources into gatherings and eucational activities in which families are already participating, e.g., churches, schools, health centers, cooperative extension. Our emphasis must be on enhancing the strengths of families and thus preventing pathologies, rather than directing our energies toward the pathologies. However, in our program of prevention, we need to keep in mind the pluralism of our society. While characteristics of strong families are similar, Herbert Otto (1979) has demonstrated that the modes of developing and experiencing that strength will vary with the culture.

At the University of Minnesota, the work of McCubbin (1980) and others is demonstrating that:

> The convergence of two parallel lines of research, the study of family strengths and the study of families under stress, appears to have potential in advancing our understanding of family behavior under a range of circumstances...The picture of family strengths which emerges from this research is twofold. First, family strengths are viewed as having an active dimension commonly referred to as coping. Second, this active process includes the family's transactions with the community, and the procurement of social support from neighbors...we appear to be moving toward a more dynamic model of family strengths which take into consideration not only what the family has internally and how it manages available strengths and resources, but how it interacts with the community in securing a vital social resource called support. (p. 189)

What McCubbin and other researchers (Burr, 1973; Hansen & Hill, 1964; Hill, 1949) are pointing out is that supportive interaction and shared information between family members and others in the community are protective against the adverse consequences of life stress. In his presidential address to the American Psychosomatic Society, Sidney Cobb (1976) stated "We have often seen strong and quite often hard evidence, repeated over a variety of transitions in the life cycle from birth to death, that shocial support is protective...that adequate social support can protect people in crisis from a wide variety of pathological states; from low birth weight to death, from arthritis through tuberculosis to depression, alcoholism and other psychiatric illnesses...We should start now to teach all our patients, both well and sick, how to give and receive social support" (310, 312).

The remarks of Dr. F. Ivan Hye (1980) underscore the emphasis of this proposal by commenting on his research on runaways.

> The research on runaways highlights the need for effective parent-education program in the United States. It will be most effective if it can be timed when the young people

> become parents--when they feel a need for information, and can immediately apply its principles. It needs to be based on valid theory and research...The preparation of valid parent-education materials requires time to search the professional literature exhaustively and care in organization and writing. Fainlly, as valid, effective materials are available, the means must be developed to disseminate them effectively to parents rearing children (p. 238).

Urie Bronfenbrenner (1979) pointed out that the field of children's service is one sided in that it knows far more about children than about how to strengthen the environment around them. The Task Force on Families of the Extension Committee on Policy recently outlined the importance both of providing eucation to families and to the agencies that work with families (ECOP, 1981; Daly, 1981).

Family Life Educators Needed

The key concept emerging from both research and practice is that in each community there needs to be a family life educator or family life education center that gives leadership to the community. The leadership will help the community to assess the kinds of resources that are currently available for families. It will help develop coordination among the different programs offered by various groups for for strengthening families, so as to gain maximum efficiency for the family life program efforts in the community and also to identify areas of family need that are not being addressed.

Various professions and community groups need assistance to relate their activities to the creative millieu present in strong families. Those professions and groups need assistance to recognize the strengths in other supportive networks of which families are a part. Self-help networks and more formal institutions, such as churches and schools, join together with families in maintaining a climate for growth and the actualization of a moral life.

The Symptomatic Approach of H.R. 1197 vs. The Preventive Approach

What is the percentage of funding proposed in H.R. 1197 for the symptomatic approach vs. the preventative approach? Frankly, only an insignificant proportion of Federal spending for mental health services really addresses prevention. As Gov. L. Douglas Wilder of Virginia pointed out, often it is the parents who need help to deal with their children, and it is not the child alone requiring an intervention. I agree with Gov. Wilder that Federal funds should be redirected to prevention and early intervention approaches. Taking a symptomatic approach by itself will create a permanent mental health clientele in the same way the ill-conceived welfare programs have created a perpetual clientele. For example, Federal requirements for welfare that restricted benefits to children of one parent families were found to destabilize marriages in poor families because the father knew that his child could receive Federal benefits if he left the child's mother. If we fund only the symptomatic programs, we will have the same dismal results that the welfare program has had for the last several decades. Congress ought to be insisting on primary emphasis on prevention approaches, not proposing these same tired old programs that primarily treat the symptoms while largely ignoring the prevention of the underlying family problems. The symptomatic approach is wishful thinking. What we have in this old approach is a profound failure to understand human nature and motivations.

Take for example, the moral failure of so many fathers in American society to provide for the emotional and financial needs of their children. The symptomatic approach, which is often tragically needed in so many cases, would point out that there are factors which can mitigate the negative influence of a fatherless home. The presence of a father substitute has generally been found to counteract, to a certain extent, the effects of paternal deprivation (Matthews, 1976; Sutton-Smith, Rosenberg & Landy, 1968). For example, Santrock (1970) found that fathers' absence in black pre-school boys was significantly related to femininity, dependency and lack of normal aggression, as compared to father-present controls. However, the boys whose fathers were absent and who had a father substitute where significantly less dependent that the father-absent boys who had no father substitute.

Another factor which has been found to lessen the effects of paternal deprivation is a positive attitude toward the father and towrd men in general on the part of the mother (Biller & Baum, 1971; Matthews, 1976).

Referring to an analogy between family wellness and the physical wellness in the human body, we know that it is possible for a person who has lost a leg to move about in society with the help of crutches. With extra effort, the arms thereby partially compensate for the missing leg. In the same way, there are ways in which families are able to compensate for the absence of a father. The research, suggests that an active and costly substitution is occurring so that features of the missing father role are taken by other individuals such as an uncle, grandfather, older brother, or family friend. Furthermore, government welfare dollars are often spent as a substitute for the loss of income caused by the father's absence.

While there certainly are families without fathers who come through with "flying colors," this is done by compensating with real efforts, much like the person with a missing leg who perservers.

The fatherless families that "make it" are those who have preserved in heroic fashion in the face of the family's limitations and associated adversity, much life the way Helen Keller achieved so much without eyesight or hearing. To say that many children raised in a single-parent home can become well-adjusted, productive citizens is true because compensation is possible, but it does not tell the whole story. The same can be said of blind people--that they can live well-adjusted, productive lives. But both the blind person and the fatherless child have missed something very desirable and crucial that could have enriched their lives and made their adjustment much less difficult and costly.

It is time to recognize that the family is indeed the primary resource system for the child, and where both parents are alive, the child generally has an easier time adjusting emotionally with the active involvement of both parents. Therefore, any approach to treat the "symptom" of child emotional disorder should be combined with preventive interventions to address the underlying family problems which generate non-organic child mental disorders. We should not continue to fund programs which treat the child as though the child is independent of the family system. We must address the major moral problems creating the family problems which are tragically all too common in American culture at the current time. Families in American society are falling apart and will continue to fall apart unless we empower the moral base of our society that promotes marriage and parental responsibility.

Any legislation which would merely fund increased community based mental health services for children in the absence of significant evaluation research and in the absence of a major prevention component would only be a short sighted bandaid approach. The suffering children certainly need more treatment as close to their homes as possible, but even more urgent is the need for prevention efforts to stem the tide of the escalating numbers of emotionally disturbed children.

By analogy, it is only humane to help feed, house and protect the Kurdish refugees from Iraq, but the US State Department would be foolish and blind if it restricted its efforts exclusively to that symptomatic problem. Indeed, the larger and more fundamental task that President Bush and Secretary Baker are pursuing is a more comprehensive and enduring peace in the Middle East to end or at least reduce the number of conflicts that produce the hungry and homeless refugees.

Similarly, we need to aggressively pursue peace for the American family to greatly reduce the extent of marital conflict and parental inaccessibility that produces the emotional "famine" for so many American children.

As you consider legislation to treat seriously emotionally disturbed children "close to home" I urge you to not limit yourselves to considering the worthy but inadequate goal of treating emotionally disturbed children--that is the symptomatic approach which potentially perpetuates mental health care indefinitely. Instead, we should be asking, "Who is at home?" and "Who is helping the parents provide for their children's emotional needs?" and so I recommend a primary emphasis on stemming the tide through prevention by creating the best social and economic climate for promoting strong families that are "child-friendly" while simultaneously investing more in evaluation research on comparative treatments of the seriously emotionally disturbed children in need of treatment near their homes.

Eight Proposals to Integrate Prevention, Intervention and Research

It is my hope that America's leaders will sow some seeds of prevention that might strengthen family life in our generation that will reap a fruitful harvest of family stability, marital success and a nurturing environment for the future children of our nation. To this end, I propose eight specific, practical proposals to help make American families "child-friendly."

(1) I agree with earlier testimony and Congressional remarks that "administrative costs" are a problem and for this reason I would recommend deleting the creation of new state agency bureaucracies as is proposed in H.R. 1197 which would not necessarily be directing dollars to needy families with their children. Instead I would propose that what the states need are block grants instead of categorical grants for children's mental health services in order to provide the kind of flexibility that Governor Wilder explained is necessary. Each state can determine its own unique set of local needs and best address those needs with flexible block grants. For example, in my State of South Carolina, the Department of Mental Health already has an innovative emphasis on community treatment of children as close to their homes as possible, and could benefit from more flexible block grant funds from the Federal government.

(2) There exists limited research comparing the effectiveness of different types of mental health services for seriously emotionally disturbed children and there has been inadequate research attention given to the potential of family involvement in psychotherapeutic intervention. Therefore, I propose that more research be funded on children's mental health services to determine the differential degrees of effectiveness of various strategies to treating disturbed children in their home communities. Instead of the massive funding of inadequately evaluated programs proposed by H.R. 1197, I recommend funding of some smaller pilot projects to first demonstrate the effectiveness of various models of community-based mental health services for children, because there have been few comparative psychotherapeutic intervention studies of this type. This type of research is necessary *prior* to massive funding a national program of mental health services for children in order to avoid needless waste of resources on unproven treatment programs. These research studies should include *early identification* of problem families and *prevention* of mental disorders in children.

It is both compassionate and in society's vital interest to discover how to build and restore strength into America's families. Frankly, the absence of the father is increasingly posing one of the most common and tragic weaknesses of American families, placing increasing numbers of children at a substantially greater risk in their development and well-being than other children living with continuity with both parents in a strong family.

Our shared cultural values mandate compassionate help for hurting and needy families. But at the same time, an "ounce of prevention" is worth more than a pound of cure in serving families. A tremendous amount of child suffering and family distress could be prevented by a national agenda to restore social expectation and public policy that support the continuity of fathering in families.

As the 1980s dawned, there was beginning to be a rising appreciation for the fact that prevention is both more humane and more economical than remediation alone. Central in any thought of prevention is the place of the family. The family shapes the attitudes and practices of children and provides the basis of support and identity for adults.

Fresh, new national leadership is needed at exactly this point. For too long, American society has attended to the individual needs of the children of fatherless homes and the plight of the single parent to the neglect of the family system before its breakdown. The result has often been only a partial symptomatic relief, or a "band-aid" approach which neglected the root problems in the original family unit itself. Isolated categorical government programs--such as those for unwed, pregnant teenagers, runaway youth, school drops outs, juvenile delinquents, or childhood adjustment problems--as important as they are--simply have not typically met the total family need which generated the individual problem in the first place.

(3) We know that it is not effective to exclude families in treating children, therefore, federally funded programs should require family interventions including family education and family therapy. Data from the South Carolina Continuum of Care for Seriously Emotionally Disturbed Children indicates that the vast majority of such children are chronic cases in their adolescent years. What is necessary is a family based treatment approach which focuses on earlier identification as well as earlier intervention in the younger childhood years. We should not invest the majority of funds in treating disturbed adolescents when massive numbers of younger children are simultaneously developing similar problems which receiving little or no effective treatment. It would be more humane to treat these younger children before they become seriously disturbed

and prevent the severe problems suffered by the older adolescent cases.

Coinciding with the 20th century phenomenon of governmentally funded, professional services for child problems, there has been a parallel tendency for families to delegate more and more of its functions to outside institutions. For example, the health needs of a family might be inappropriately delegated entirely to the health care system and physicians, thereby neglecting the proper parental roles in preventative measures for health maintenance. While professional services can be effectively used by parents who maintain their own primary involvement and responsibility for their children's welfare, the attempts by many parents to massively delegate or abdicate parental responsibility to government, professional and community programs has not proven to be an effective substitute for family well-being and parental accessibility.

The parental role is central in encouraging youth and in providing for their needs for the largest portion of mainstream American families. For example, the parenting practices of many families promote a work-orientation and successful job acquisition and employment retention by youth, and other families could benefit from the identification of those practices and the widespread application of those practices. The needs of child and youth development and the goal of prevention of serious mental disorders will be best served by reinforcing the value and centrality of the stable family unit and parental role. Marriage relationships and parenting roles can be strengthened to give children and youth more confidence, self-respect and competence to succeed in today's world.

Many serious human development problems and marital conflict could be prevented or corrected in early stages if families were better equipped to recognize family strengths and to build upon those strengths. Many needy families could benefit from learning about the successful and preventative practices commonly used in families with high levels of marital satisfaction and well-being.

The initial step toward eventual dissemination of information on building stronger families would be to gather research and family life education materials which identify relationship factors of successful marriages and families. For example, the parenting practices of many families promote a work-orientation and successful job acquisition and employment retention by youth, and other families could benefit from the identification of those practices and the widespread application of those practices.

The root problem of many categorical dysfunctions (such as pregnant teens or runaway youth) is in the family system, including the marriage relationship. To address all social service efforts to the remediation of the categorical problem of severe emotional disturbance can constitute only symptomatic relief, rather than addressing the underlying family need.

There has been a parallel tendency for families to delegate certain functions to outside institutions. For example, the health needs of a family might be inappropriately delegated entirely to the health care system and physicians, thereby neglecting the proper parental roles in preventative measures for health maintenance. Parent education curricula on family health need to be catalogued in order to foster greater dissemination to voluntary/private local community organizations.

The federal government has a potentially strategic role in promoting the efficient gathering of informational resources on how marriage relationships and parenting roles can be strengthened to give children and youth more confidence, self-respect and competence to succeed in today's world. The parental role is central in encouraging youth and in providing for their needs for the largest portion of mainstream American families. The needs of child and youth development and the goal of prevention of serious dysfunctions will be best served by reinforcing the value and centrality of the stable family unit and parental role.

Often, there are strong and effective resources available from a variety of sources, which exist in "bits and pieces" in various places around the country. Unfortunately, the local volunteer community worker (such as scout leader, church education director or youth leader, or PTA leader) does not typically have the awareness of the availability of these family life education materials, nor the time to put them together in a sequence of programming which could serve to better equip families to prevent problems. Therefore, there is a need for an informational resource center to gather this strategic set of materials, to catalogue them, and to thereby increase accessibility of the materials already available.

A federal information resource center could also gather data and research study results on variables which have an impact upon marriage and family life, with an emphasis upon the preventative goal for improving family life in America.

It is important for families to have continue guidance concerning ways to achieve a successful marriage and family life. That guidance should include: 1) models illustrating family strengths, 2) opportunities to develop necessary skills, and 3) opportunities to consider developmental changes in their families and in the culture around them. This may be done in separate family life programs. It will most frequently be done as different agencies and groups in the community interact with families and family members in the normal course of life events, e.g., children entering school, middle-aged parents considering retirement. Therefore we need to assist those agencies to be prepared to provide appropriate marriage and family education resources to the families they encounter.

There is a growing body of information on family life and a growing interest in developing family life programs. However, there is a problem of getting the information to the families. Families do not have time and/or they sometimes experience the psychological obstacles to come to special programs in the community on family life education (Cromwell). The most effective strategy seems to be to take family education into gatherings and educational activities in which they are already participating.

Efficient and useful training materials could be developed and made available to community leaders to assist them to develop family life education programs. Their programs would help families affirm and develop their own strengths and become prepared for establishing and maintaining family support systems as part of the larger community.

New family life education approaches could be developed and promoted across the nation (a) to foster family self-sufficiency, (b) to help promote the moral values that preserve marriages and promote family stability, (c) to help prevent neglect, abuse, or mistreatment of vulnerable family members, (d) to promote family care for independent living as an alternative to institutionalization where possible, and (e) to stimulate the improved use of private voluntary organizational resources to deliver human services to families experiencing crises or stress.

To decrease the number of broken families, we need (a) to promote local service delivery to families which is effective and cost efficient, (b) to facilitate family life education program evaluation, (c) to train local community leaders in marriage enrichment education, (d) to develop model curricula on strengthening families for potential nation-wide use, and (e) to build the capacity of local organizations to meet human and family needs, instead of turning to governmental services.

Many of the existing privately-supported community service organizations have historically been interested in preventative, educational and "wellness" human services. However, they could be better equipped to serve families if training "packages" on parent education were more readily available, and if a nationwide training program were available on a regional basis to train volunteer community leaders to conduct marriage enrichment and parent education workshops and seminars on the themes of prevention and building family strengths.

So, with proper training curricula (printed, film and/or videotape), plus training sessions for workshop leaders (church youth directors, scout leaders, PTA leaders, charitable organization volunteers), existing private organizations could provide training services to better equip married parents to build family strengths and competence and to thereby prevent many occurrences of child and youth dysfunction.

Child development research supports the vital need of children to have competent parents providing for their needs. Parental nurturance, love and involvement with providing resources (emotional, educational and economic) to children are of primary importance. Preventative premarriage education and parent education programs carried out by local volunteer community leaders could be vitally supportive to that pivotal parental role. In this way, parental competence can be highlighted, more effective parental responsibility for their children's welfare can be promoted, and the incidence of divorce and separation could be decreased.

By providing effective program packages that stimulate volunteer leadership in family life education, there will be an increased responsiveness of the private and voluntary sector to the needs of families.

By direct practical educational opportunities for voluntary community leaders to learn how to use family enrichment education materials, there will result an increased family access to useful and relevant information which will enable them to more effectively cope with stresses upon the marriage relationship and parenting role.

By providing community service organizations the training materials for parents together with workshops to train the trainers, the efforts of those community service organizations will be increased to use volunteers in child, youth and family services.

And by providing these regional volunteer training sessions on the use of family life education materials across the nation, the result will be an anticipated increased in the involvement of the private and voluntary sectors in developing workable alternatives which will ultimately reduce the need for programs serving children, youth and families.

The best training materials need to be identified from among those successfully used in some local communities already. This would enable the widespread application of the same materials in the other communities of the nation.

The training packages on the parenting role may need to be compiled in different formats for various constituencies, to be maximally available and useful. Part of the assessment of the available marriage enrichment and parenting materials would take this factor into account, thereby providing several optional formats for the curricula assembled.

While there is growing activity in marriage enrichment and family life education around the country, people at the grass roots are largely unaware of the materials. And when they encounter one set of materials they do not know what else is available and therefore they often feel concerned about using it. They need an opportunity to know the range of materials that are available and how to choose and relate the materials to their particular constituency.

In an article setting forth the importance of making family life education available through the many avenues and organizations where families are normally encountered, the Guerneys (1981) listed such agencies as The National Childbirth Association, la Leche, family service agencies, consultation and education departments of mental health centers, and pediatric departments.

There is a growing desire around the nation to develop programs of prevention through offering parent education, marriage enrichment and family education that hep families recognize and build on their strengths.

Existing community leaders in private volunteer social organizations need both training and programming materials to motivate and equip individuals and families to provide natural networks of social support and service to one another, to thereby decrease the incidence of separation and divorce, which in turn should decrease requests for government services. New methods and innovative techniques need to be developed to foster private and voluntary social service support to families. The Office for Families in the Administration of Children, Youth and Families in the Department of Health and Human Services could be funded to develop local leadership training procedures and family life education program materials for widespread applicability to many types of private, voluntary community organizations, including scouts, YMCAs, counseling centers and churches. These training procedures and family life education materials should be mandated (1) to promote the values of family stability, (2) to provide training to families on how to strengthen marital relationships, and (3) to emphasize the father's important role in child development.

The President's Commission on Mental Health (Task Panel Reports, Vol. II, 1978) made the following observation and recommendation:

Social and community support systems can help to contribute to a sense of well-being and of competent functioning (and thus be preventive). They can aid in reducing the negative consequences of stressful life events and thus bridge the treatment and rehabilitative levels of prevention. What is even more significant is that utilization of social and community support systems can provide for constructive innovation and systemic change...moving toward a comprehensive human service system with a holistic orientation that would remedy some of the defects of our present fragmented and uncoordinated efforts.

The Task Panel on Community Support Systems recommends a major new Federal initiative to achieve the following objectives:

> Recognize and strengthen the natural networks to which people belong and on which they depend--families; kin, kith, friendship, and neighborhood social networks; work relationships; religious denominations and congregations; and self-help groups and other voluntary associations based on principles of intimacy and mutual aid. Develop educational strategies to inform the general public and caregiving professionals on the nature and function of natural helping networks and on the importance of attachments and mutuality for well-being.
>
> Initiate research to provide national data periodically on social support and on natural helping networks in American society, to monitor the direction and magnitude of changes in these aspects of American life, and to increase knowledge of how best to attain the above objectives.

Task Panel Reports, Vol. II, p. 144

The Task Panel noted further that religious institutions represent a major, "partially tapped" resource (Task Panel, 1978, p. 192). Veroff (1976) found that more people said they would turn to clergy than to any other helping professional in time of need. (Task Panel, 1978, p. 192).

...Also, churches and synagogues are the major transgenerational organizations in most communities and thus have exceptional opportunities to help people cope creatively with the developmental crisis which occur throughout the life cycle and help build communication bridges between generations." Task Panel Reports, Vol. II, p. 192.

The literature that describes the effects of support network involvement clearly indicates its potential for the reduction of requests for services currently provided by the federal government. For example, there is indication that network participation reduces incidence rates of family violence (Caplan, 1974), assists in adjustment to divorce (Heatherington & Cox, 1977), and even affects adjustment rates to societal issues like economic depression (Drabek & Boggs, 1968).

There is a need to transfer existing knowledge on how to build family stability and to enhance family support networks to local community service organizations and private charitable organizations which have enormous potential for providing preventative social services in a volunteer framework.

Too much federal spending in the past has assumed that the incidence of broken families will continue to escalate unabated and that government should only finance (such as H.R. 1197 proposes) a growing list of specialized social and mental health services where professional workers try to patch up the side effects of broken families on children--such as delinquency, runaways, school failure, mental disorders, health and nutritional problems and child abuse. Instead, a greater portion of federal spending should be redirected to the more strategic use of resources to develop improved cost effective methods of addressing social needs of individuals and families at the community level, and to promote the building of family strengths and self-sufficiency as well as effective volunteer human services, and to evaluate demonstration projects with potential for widespread national application without continued federal funding.

More funding should be directed to the Office for Families with the requirement that projects be funded to prevent divorce and separation in the first place. New projects are needed (1) to develop and enhance national social and community support systems by training leaders in community churches and synagogues to conduct preventative family life education programs; (2) to evaluate the effectiveness of programs in strengthening the natural community helping networks and social support to families facing marital problems; (3) to thereby provide family stability, to decrease the probability of family break-up (divorce and run-away children), to strengthen families and to be able to care for the handicapped, the aged, and others at home as an alternative to government-subsidized institutionalization; and (4) to provide family cluster support groups in local organizations and congregations where families can help other families in short-term or long-term stresses which would otherwise result in divorce or separation or institutionalization of an individual in the absence of such support networks.

Margaret Sawin (1981) has reviewed many ways in which church and family interests are reciprocal and make the church one logical and concerned place for dealing with family issues. While the minister, priest or rabbi is the key leader, the majority of clergy have only had "training in the area of remedial work rather than prevention or enrichment" (Sawin, 1981, p. 533). Federal programs could provide training and curricula to support local active programs of family education which focus on helping families in communities to recognize and build on their strengths, to establish both a strong bulwark of prevention as well as a community of families capable and motivated to reach out in supportive and caring ways to individuals and families in stress.

New materials need to be developed to be used to train leaders in the existing structures of local organizations, churches and synagogues to build strong families. Two types of materials need to be developed: one for leaders and one for the participating families to be implemented in existing local community settings, thereby tying into and enhancing already existing helping networks. The federal government could thereby mobilize existing leadership in ongoing local social institutions who in turn can mobilize the strengths of families into a preventative action oriented program.

Materials could be designed to have an effective impact on two levels. First, the training curriculum could be designed to strengthen families by developing skills that past research has shown to be associated with strong families (Stinnett, et al., 1978). This is an effort to prevent families from being overwhelmed by crisis associated with drug abuse, foster home placements, requests for mental health and family services, etc., thereby enabling families to rely on their own social networks rather than being forced by circumstances to rely exclusively on governmental social agencies. Second, there could be a useful application of these skills to the formation of family support networks within the local community in conformity with the recommendation of the President's Task Force on Mental Health (1978).

Since such materials have not yet been systematically and comprehensively developed and since they would have broad application to many settings such as work, clubs, churches and schools, it is critical that they prove to have high effectiveness and be as cost efficient as possible. Because the materials would be intended for widespread application for minimal cost to potential users, evaluation of program results assumes particular importance as a way of assuring dissemination of only a program of demonstrated quality and effectiveness.

If the federal government funded the development of family life education materials, they would then be available for use on a widespread basis at no additional cost to the government. Scout groups, PTAs, churches, YMCAs, local service clubs and other voluntary community organizations could obtain the training materials for a modest cost. They likewise could order curricula for individual families, or families could purchase their own booklets. In such voluntary organizations, it is anticipated that there would be virtually no new paid staff to implement the family life education program. Therefore the widespread use of this program is fundable on its own. Community leaders could be provided valuable training on how to encourage families to develop into support networks which could greatly enhance marital and family stability.

This approach is feasible, also, because the community structures already exist for its implementation, and the principal trainers already meet face-to-face with numerous families weekly and their organizations have weekly publications to communicate new and innovative programs such as this. Existing families are caregiving units and this strategic participation by the federal Office for Families would be useful and efficient in equipping families to maintain and to build their caregiving capacities.

The widespread use and application of federally developed family life education materials fostering family values and skills in preserving marriage could result in less institutionalization of youth, as families are better equipped to recognize growth processes and to rely on local support networks. The proposed curricula could encourage and help to equip families to take children and youth with developmental disabilities or other social problems, or aged and infirm individuals into local homes of other families for short-term crisis care which would reduce demand for governmental funding of additional foster care or institutionalization. This promotion of family clusters in communities should benefit lower income children and families. The skills in family life to be taught in the curriculum materials should not only strengthen individual marriages and families but also equip some families to provide for the needs of other local families in social outreach.

(4) Any attempt to treat or to prevent childhood mental disorders needs to address the massive problem of substance abuse in our society because of the devastation to family relationships that result when a parent, a child or adolescent is addicted to an illegal substance. For this reason, the federal government should escalate its war against illicit drugs and design ways to curtail the level of smuggling of illicit substances across our borders into our neighborhoods, and should provide stronger law enforcement to lessen drug abuse.

(5) I agree with Congressman Frank Wolf who has proposed indexing the dependent tax exemption for inflation. This would constitute a preventative approach by restoring economic resources to the very families who have dependent children. The tax exemption for each child should be indexed for inflation from its level in 1950 to the present. This would allow many families to choose to have one of the parents remain at home to provide the supervision, nurturance and accessibility that promotes emotional adjustment and prevents serious emotional disturbance.

Under the heading "Home Alone," Michael Barone reported the following in the May 6, 1991, issue of U.S. News and World Report (page 42):

"Democrats have operated on the theory that these voters want the same thing their baby-boom elders seemed to want: economic redistribution and liberation from traditional cultural restraints on behavior. But in their new book, "Generations," William Strauss and Neil Howe paint a picture of this "Thirteenth Generation," born since 1961, that yields different conclusions. These were the latchkey children left--in words of the hit move title--home alone by liberated parents, left to learn for themselves by permissive educators and left to earn money for themselves after school rather than collect sufficient allowances from their parents. They haven't gotten much economically, and they don't expect much. Like Walter Polovchak, who in 1980 at age 12 refused to go back to the Soviet Union with his parents after a year in Chicago, they like the America around them but know that what they want they must get on their own. They have learned from their experiences and their classmates that economic status depends on personal effort and decisions: The biggest change in lifestyle happens when a two-paycheck family becomes two one-paycheck households after divorce, which is a problem that can't be blamed on society or government. These young Americans are looking not for redistribution or liberation but for order--a predictable, rational framework in which they can work to achieve their private goals."

The federal role needs to be reconceptualized to analyze family impact variables, to determine the impact of national policies, regulations, taxation and legislation upon families and to publicize how successful marriage and family life works. It is doubtful that the federal government can directly influence families to be strong in American society; the causation more likely runs in the opposite direction--i.e., strong families contribute to the strength of a nation. However, the leadership in federal government should be held accountable if they create a "desert" environment for families when they should be creating a "greenhouse" in which families can flourish.

Prevention is always more humane and more economical than remediation. My recent book, Family Building (Rekers, 1985a), includes contributed chapters by researchers, clinicians community and national leaders which provide innovative, prevention approaches to enhancing and restoring strengths to the nation's families. I commend for your consideration these creative program ideas on promoting marital stability and parental competence, because American children develop fewer debilitating problems when provided stable and nurturing relationships with their fathers. The recognition of the qualities demonstrated to be essential for family strength can guide the national agenda to attenuate the social and economic forces that contribute to the undesirable types of family diversity.

(6) The U.S. Congress should remove all income tax provisions and all federally funded program features that penalize marriage of parents of minor children. Federal policy should encourage marital permanence and not encourage divorce. Marriage should not disqualify a family for welfare benefits. Marriage should not increase taxes paid compared to the rates if both were single. Tax policy should encourage marriage and providing for children. Along these same lines, Congress could provide incentives for adoption by

giving an income tax dependent exemption for each adopted child that is six times the amount for other dependents.

(7) I agree with Congresswoman Patricia Schroeder that the public media could be constructively used in a nationwide campaign to promote family well being; for example, educational television programming could describe the six characteristics of strong families and provide positive models for how these could be incorporated in families to make them "child-friendly." Furthermore, the media could promote the positive virtues of adopting children, especially children who languish in prolonged foster care in the absence of an available adoptive family. Television can be used to promote family values and family education to equip families to recognize and cultivate their strengths can create a new vision in our communities--a perspective that says that preparation for family life is part of our nation's plan of primary prevention. It is a basic part of education for citizenship and health.

Research clearly shows that the vast majority of adult and child citizens in America desire continuity and enduring commitment in father-child relationships, rather than having to suffer the loss of a nurturing and supportive father. In the face of pessimistic headlines that the family is an endangered species, research sets forth two important findings: (1) desire for fulfilling family life is as strong today as it was 50 years ago, and (2) effective family life does not just happen, it is the result of deliberate intention and practice. The television and radio media could be used to teach families how to strengthen their family in practical ways.

George Gallup (1983) has repeatedly found in his polls that Americans hope and aspire for an intact, nuclear family. On the part of children, Wallerstein has reported the findings of her extensive research on divorce that children desire that their biological parents be reunited as long as five years after the divorce had taken place.

Many serious marital and child development problems could be prevented or corrected in early stages if families were better equipped to recognize family strengths and to build upon those strengths. Many needy marriages would benefit from learning from books and TV about the successful and coping practices used by families with high levels of well being. There is a glaring need for more prevention strengthening of family life to offset the need for expanded governmental financial support for remedial social services for child victims of fatherless families.

Marriage enrichment and parent education programs on TV could promote the values and skills possessed by strong American families.

Broadcasting could lift up family strengths and focus on how they can be transferred to families at risk for divorce; this would be a most significant undertaking with a far reaching potential benefit to children and to society, because divorce is a major cause of father absence in families and a major source of distress for American children. As Petersen (1985) astutely observed, "Our zeroing in on the positive qualities of family strength has great potential and can provide clear guidance as to where to give attention and to initiate action." I recommend that this strategy be attempted on a national media level to strengthen America's families. This could be accomplished by federal funding for this specific purpose to the public television network, requiring participation of recognized moral leaders in local communities.

(8) Any federal funding for community based programs for emotionally disturbed children should recognize that the goal in treating an emotionally disturbed child is to eventually be able to terminate treatment and return the child to family and community social supports. Furthermore, it has been demonstrated that psychotherapy can never replace the kind of nurturance and positive input that close family relationships provide (Nicholi, 1985). This was emphasized in the April 1991 issue of Journal of Personality and Social Psychology which reported the findings of a 36 year study that links parental warmth, hugging and cuddling of children to better mental health, work success, and marital satisfaction in adult years. This research by Drs. Carol Franz, David McClelland and Joel Weinberg found that parental warmth experienced in childhood resulted in greater security in the individual as they grew up. Dr. Armand Nicholi of Harvard University has pointed out, "If we know anything about normal human development, it's that it rests on a close, warm, sustained relationship with bother parents" (Nicholi, 1985). Local community organizations that work with families and children could be encouraged to provide educational programs on family life, and any treatment programs for children should cooperate with the voluntary community organizations by referring families to these organizations who can provide social support networks for families after the completion of treatment; for example, referrals and cooperative efforts need to be made with scout programs, PTA programs, YMCA and YWCA programs and child service club organizations (such as Brigade Scout programs found in many churches). We need to realize that fewer American

children live near extended family members and so these volunteer community agencies have even more significance and should be encouraged to match needy families with strong families who could provide a model of family relationships and provide additional support. Federally funded treatment programs should be required to include action plans based on the available empirical research which demonstrates that religious involvement can serve as a buffer to psychopathology after treatment is completed (see Larson, 1985).

Research indicates that family connections with local support networks decreases need for use of a variety of governmental social services. Research has also established a high correlation between religious commitment and family commitment; this finding underscores the strategic importance of encouraging the work of religious institutions with family education and their involvement with natural helping networks for families (Rekers, 1985a). Volunteer resources can be activated by providing effective preventative educational materials for local programming to enhance marital satisfaction and parental competence, nurturance, and human problem-solving skills. Dissemination and widespread utilization of demonstration project findings on building family strengths could effectively facilitate private and local agency efforts to prevent family dysfunction and thereby promote more stable and adaptive child development.

Conclusion

Any Federal program to address the mental health needs of children in the U.S. should have a *primary emphasis* upon practical *prevention* interventions as addressed to the major family problems contributing to non-organic mental disorders in younger children, together with an empirical *evaluation research* component of the community-based treatment intervention services delivered to the seriously emotionally disturbed children and adolescents.

REFERENCES 1 THRU 135 FOR TESTIMONY OF GEORGE A. REKERS, PH.D., IS RETAINED IN COMMITTEE FILES

Chairwoman **Schroeder**. Thank you very much.

And I think we are going to have one chance to do that very, very soon, and that is the bill H.R. 2, the Family Medical Leave Bill, which we hope the President is going to sign this time, but that to me is one of the very, very important things that we are so far behind on.

So I agree with you. We should look at prevention, but we also want to focus on services. We want to make sure we have got both things there.

Let me continue on by letting other people ask questions first because, again, of our delay. Congressman Wolf.

Mr. **Wolf**. I thank you very much.

I want to thank all of the panel members. Let me just go down the line and ask one or two questions and each of you may answer.

What prevention efforts would you take to keep what is taking place from taking place? And you can each answer in turn. That was the number one point that Governor Wilder raised. So what would it take? What would you do, briefly so that we have time to get everybody?

Dr. **Rekers**. Okay. I would just briefly mention eight specific prevention proposals that I am going to submit in my written testimony, and some of these endorse what Governor Wilder was saying.

First is to provide block grants as opposed to categorical grants to the states in order to provide flexibility.

I know in our State of South Carolina, we already are trying to work in the Department of Mental Health on getting services closer to the child's home, but block grants give us more money to get early identification, and prevention services to the families.

The local states need to best determine what is needed in a community setting, and we do not need to create new state bureaucracies or central coordinating and this sort of thing. Let the states decide how to handle that.

Secondly, we need to fund more research on children's mental health services. We need to see what strategies work and which do not. You know, a lot of times the intuitive notions do not work, but the approaches that involve the family are going to be those that are most preventative because many of the children that we see in the Department of Mental Health in our state are siblings of previously treated children who repeat a family's access to the system.

So we must identify a problem family, and we need a more preventative approach which would be to get behind just the individual child who is a recipient of categorical programs and treat the family dysfunction that is behind those child problems.

Thirdly, we need to require family interventions and not treat the child as though the child were an individual entity. We need to determine what the resource system is for that child, and that is usually the family.

Fourth, we need to do more in the war against drug abuse because substance abuse is behind many of the family dysfunctions. If you look at alcohol and substance abuse of parents, you see a big cause of many of our children's problems.

Fifth, I agree that we need to index the child tax exemption to create a more favorable economic environment for families. We need to create a "greenhouse" for families to live in in our society, not a "desert" where they can just barely make it, and one way to do that would be to index that tax exemption from 1950 to the inflation factor, and it would go even beyond the bill that you had proposed, leaving more resources to the parents.

Sixth, we need to endorse model legislation for the states to relook at the the easy, "no fault" divorce laws which result in putting the women and children in greater poverty as the Stanford studies show and making the fathers more wealthy. We need to reverse that. So divorce is granted only for just grounds such as chronic physical violence or adultery.

Seventh, we need to strengthen child support enforcement.

Eight, we need to promote services not just by mental health professionals. We must realize that what provides a "greenhouse" for the family are not only mental health services, but other factors in the community, the PTA, the Scouts, the voluntary community organizations, the churches, the research that you cited, Mr. Wolf, on the characteristics of strong families. Those make families more child-friendly, and we need to be supportive of community organizations that build family life and promote mental health even after a child leaves treatment.

Hopefully when we treat the children in the mental health system, our goal is to get them out of treatment and functioning well. Well, we ought to be looking more at promoting those community organizations that support children out there in the private sector, and we need to realize the research shows that religion is a buffer for psychopathology and reduces the need for treatment in many cases.

So I will flesh out those proposals in more detail in my written testimony.

Ms. JORDAN. I guess I almost feel like this is a rebuttal to George, and I do not mean for it to sound like that, but I am absolutely convinced that we do terrible disservices to families by calling families dysfunctional without being able to identify that in the context of culture.

None of you would know what it meant if I said, "Hey, you are a dysfunctional bureaucrat." What does that mean? So I would prefer not to use those kinds of words in describing family needs.

Rather, I think if we begin to support families in a holistic way and ask them what they need—I have not heard a single person here say we should go into a home and ask the mother or father "what is it you need for your child? What is it that you would need to support your family?" And I think we need to do that.

I used to call my grandfather. I started out doing little workshops in Minnesota and then big workshops in Minnesota, and pretty soon I was talking to some people nationally, which has always been very terrifying for me, and I used to call my grandfather and say, "Grandpop, you know, what should I say?"

And you would have to know my grandfather. He had these long, long pauses over long distance telephone that I got to pay for before he responded. It is a cultural thing, you know, and he would be very quiet, and then after a while, he would say, "Granddaughter, there is nothing new under the sun."

And then I would say, "That is not a whole lot of help."

And he would continue with, "But the wisdom of the ages are collected in the body of people you will address."

We know what the problems are. I cannot see any real tremendous value in research except to substantiate what we know works. We know what does not work.

Do we keep putting money into a system that does not work simply because we do not have 20 years of proof as to what does work? I say that sounds foolish.

So I would like to see us support families in a way that takes into account what they want and need, and not as "dysfunctional units" and not as "nonfunctioning" parents.

I take telephone calls from parents every day, ten, 15 or 20 calls every single day from parents of kids with serious emotional disorders. Some of those parents are in abusive relationships with their spouses. Some of them drink too much. Some of them are heavily into drug abuse. Some of them do not feed their children in the mornings.

I never have met a parent in all my seven years at PACER Center in Minneapolis, who, when you scraped away all of the extraneous elements entering into that conversation, did not know what they needed and did not know what their child needed. Still we fail to ask those questions.

Dr. ATTKISSON. I think from the perspective of the research program that I discussed that limited public funds and public policy should focus in terms of prevention on children who are in out-of-home placement or at risk of out-of-home placement, and that the treatment and service programs should be aggressive, case finding programs that focus on continuous case management that integrates education, social services, mental health, public health and juvenile justice programs.

It is beyond the scope of what I am prepared to say today to address the more, I think, contextual economic issues that I believe relate to the difficulties in maintaining the fabric of the family in our community. Many of the children, who are served by the California programs that I have studied, do not have families. There is no resource other than the surrogate of the state or the county.

These are children that need to be targets for adoption, or for enriched therapeutic foster home placements. They need to have stable environments. That is the best bet in terms of prevention that I know.

It is not primary prevention, but good secondary and tertiary prevention, and I think such an effort has the best potential for the long-range preservation of these human resources.

Dr. CORNELIUS. I think the question was prevention. In addition to the items already discussed, I would like to suggest that you need to go to school or at least go through courses and training to drive a car, to get a license, to do all of these sorts of things. Being a parent is one of the few things that you do not have any requirement for any kind of training, education. It is the school of experience.

Building on Dixie's comments, I would make these kinds of items, this kind of education, this kind of support and training. It replaces for some the families that are not there. It builds on the experiences of others. I would make them available in day care centers.

One of the beauties of Head Start requires parental participation. In the maternity wards, in all of the cash grant offices, make services available. I think you would be surprised at how many people would take advantage of the information that would be available.

Dr. **BEHAR**. Coming almost last in this line, I can agree with almost everything that was said and to try to perhaps narrow this a little, let me mention that the very children that we are talking about, the emotionally disturbed children, whether we are talking about the five percent who come for services or the two percent who are seriously disturbed or the 20 percent who have mental health problems, the one thing we know about them is that they are the parents of tomorrow, and they will have children. So anything we can do to strengthen them as future parents becomes very important.

All of the things that have been said are important in strengthening those children, as well, but our focus on treatment has to be important as well. It cannot be ignored because we have some idea, I think, of what the next generation might look like in the absence of strong parenting.

Ms. **HUFF**. I am not going to add an awfully lot to this other than I think that, like Dixie, we have to have a totally different attitude about what we believe in with families, that they do not get up in the morning saying, "I think I will abuse my kid today," or that, "I think that I will do this or that."

I think that we have to look at strength of families, and we have to look at that as prevention. We have to build on strengths that families already have. We have to know that kids are better off in homes with families, and we have to look at—I look personally at prevention as prevention of out-of-home placements, and I know that that is different from the kind of prevention that you are talking about in terms of primary kinds of prevention, but I also agree with everything everyone else has said about what they need to do in terms of work with families at an early time.

I do not think I will add anything more to that other than I think that this whole idea that families are dysfunctional and family functioning—I do not like that at all, and I see the system as dysfunctional, not families, and we see it every day in our office and in our state level program, and we advocate like Dixie does, with families all day long.

People will say to Dixie and I both, "Oh, we just wish we had parents like you all to work with," and the fact of the matter is they are not any different. Most of them all care about their kids, and they want to keep their kids at home, but we become just absolutely blithering idiots just trying to make it work without the services that we need to promote that.

So I think that the services that promote what families say they need are what we need to do at a much earlier time.

Mr. **WOLF**. Thank you. I will not ask any more questions.

I guess I would agree with most of what you said. I do not know the answer as to why this is a greater problem today than it was 25 years ago. I think your comment with regard to parenting is very good because I think the extended family is not as strong today as it was in the past.

I was raised in South Philadelphia and Southwest Philadelphia. My grandmothers and grandfathers on both sides were basically within the neighborhood. The aunts and uncles were there, and the cousins were there, and there was such support that if something went akilter or went off, they were there.

Now, it is not uncommon in most areas of the country to have grandmothers and grandfathers and mothers and fathers on the West Coast when they are on the East Coast. If a mother or father or grandmother or grandfather is not there telling the son or the daughter how they did it or is not there to take care of the family, it is very tough.

You do need a permit to get your drivers license to go out and drive, which is important, but yet you can have a child and have no training. I remember the first time I brought my first child home. We have five children. My mom and dad and relatives were all back in Philadelphia, and I was down here, and it was difficult.

So I agree with all that you said. All of the things seem to be tougher now than they were 25 or 35 or 50 years ago.

I have no additional questions. Did you want to make a comment?

Dr. CORNELIUS. Can I say one other thing, a comment that has not come up in the testimony so far?

In some ways treatment for children with serious emotional disabilities or disturbances might take a page out of the mental retardation booklet in the sense that most of the services that are now available in the public mental health system are based on an episodic concept of mental illness. You have got a crisis today. We will go in, if we can, and help you today, and then the system walks away from that family.

Whereas in families with disabled family members, the system basically says, "We are going to be with you there most of your life. I mean sometimes we will be with you there a lot. Sometimes we will be way back, but you will know our number, and you can call."

That is another very, very grave problem with our system. We only go when the problem is a ten, and we are not there for people zero to nine. You heard some of the examples from Dixie, but that is true throughout our nation. We are really only there in crises, and that is bad.

Chairwoman SCHROEDER. Thank you. I think that is a very valid point.

Congressman Miller.

Mr. MILLER. Thank you.

First of all, let me just say that I am a little disturbed that the suggestion here is that many of these children are coming from families that do not have sufficient religion or two parents or a value system. We have dwelled greatly on the number of children who are in the public system, but we know that the vista of families involved in this problem is much greater than that, and we also know that many people are beset with mental illness and disorders that would come from what we consider model families.

The suggestion that somehow this only comes out because a family is dysfunctional or only if a family is in this situation, I think, is to ignore the range of families that encounter this problem and the settings in which these children come to the system in one fashion or another, whether they go to a private psychiatric hospital or whether they come to us through CHAMPUS or they come to us through the foster care system or the juvenile justice system. I think we ought not to lose sight of that.

If we knew simply what the target family looked like, we would start looking for the emergence of that disabled child. In fact, what we know is we are constantly surprised when our neighbors and our friends call us and tell us about an episode that they are having, and we would think, "Never in that family," or "what is the reason for this?"

So I think we may be doing a little bit of an injustice. I think also that that same argument does some injustice to the struggle that many, many families engage in to hold themselves together and to deal with these problems, and to the fact that they are engaged in a dysfunctional system that is not attuned to engage in them at a lower threshold when prevention still may be an option, when in-home treatment may still be an option; that we have a system, and this was recognized when we wrote and I authored the Foster Care and Adoption Reform Act, to try to move away from. We now are engaged in a second wave of recognition that a system that is based upon plucking a child out of a family and maybe never returning that child because the statistics still relatively are true. Eighty percent of those children who spend six months in the system will spend their entire childhood in this system away from their families, and 80 percent of those families were never offered a service prior to taking the child away, and 80 percent of those families have not been offered a service after the child was taken away.

Until we look at something like the Fort Bragg program and we look at the Ventura program, the California program, we didn't know that all across the country these efforts are now being engaged in on behalf of communities and counties and states, call them family preservation; call them early intervention; call them comprehensive services. The fact is it is right in front of our eyes, the model that now works.

And what these communities are showing is that, in fact, it can be replicated time and again, based upon assimilating what strengths are present in that family and building on others that are not there, but working with those families.

When we see that potentially the extrapolation, in the State of California is the potential savings of $171 million; think of what it would mean to reinvest that money right back into this system for the expansion of additional services for additional families early on.

But I suspect what some people would suggest is we could save that money so we could put it to another use. The question is: will we be willing to reinvest that?

I think as we engage in child welfare amendments later this year from the Ways and Means Committee and from the Commerce Committee on my legislation and others, we have got to understand that as somebody said earlier, this allows us to build a dual system, and eventually cut over to the other one.

We have got to move out of this highly intensive placement system into a service system that allows families to function and participate and learn and be educated and all of the things that sound too soft for Members of Congress to do. The only thing is that is what saves families. That is what reunifies families and works on their strengths.

But it is going to take time to move from that. This is what disturbs me about the change in direction now of the CASSP Program. While communities are hungry for the reorientation of these systems, recognizing not only economic savings, but what it can mean to families that are engaged in incredible struggles, we are now talking about again doing a different type of research rather than bringing together the services of what we know.

And the Robert Wood Johnson Foundation and others have really got to be commended for what they have done. The question is whether we will build on that model and recognize that we have been given a plan of investment, the payoff of which we have not seen as members of Congress in a long, long time, except maybe for something like Head Start or WIC. The kinds of returns that the California plan may be starting to show us is something that we would love to go home as public policy-makers and trumpet from the mountain tops that we were able to utilize money that effectively and also to deal with the families.

I think that the CHAMPUS program that you have outlined is just remarkable in terms of—I forget what the term of art was that you used—but the single entry system, and to be able to focus on the families and ask the questions about their educational supports and social service supports and what the family needs and those kind of things.

You know, we originally found out in foster care one hell of a lot of families spun into violence and children were placed in foster care because a refrigerator broke down. That $300 refrigerator or a car to go to work would have been a hell of a lot cheaper than the $3,000 a month placement.

There are a lot of things that if we ask families they can tell us about their needs. I think that is the model that you are presenting to the Congress, whether it is in the military system or in the public system, and later we can deal with the private insurance system. We will get to that later. There is a real opportunity here to build a family-based system, and God knows those families are going to look different than they did 25 years ago.

They are going to come to us with more stress, fewer resources perhaps than any generation, but do you know what? When we talk to most of them we see they are still engaged in trying to hold together those principles that we think we want to embrace in terms of family, be they single parent, dual parent, substance abusers or what have you.

As you pointed out, Dixie, you strip it away and you still have somebody that is trying to figure this thing out. That does not give us 100 percent success, but we talk about prevention and we talk about investment, and I think we have arrived at a point in terms of mental health services where it is right here in front of us if we are willing to make that commitment.

And we will be delighted if at some point that means that the placement industry is out of business. I do not think that will happen, but I would be delighted if these institutions and large group placements could be substituted with family-based services.

So thank you very, very much. The action is ours. The response is ours, whether or not we are willing to react to it.

Chairwoman **Schroeder**. Thank you.

Congressman Weldon.

Mr. **Weldon**. Thank you, Madame Chairwoman.

And let me thank all of you for your excellent testimony and for the comments and recommendations you have given us that hopefully we can work together on.

I join with the Chairperson of this select committee as an ardent supporter of the family and medical leave legislation and look forward in a bipartisan way to seeing this Congress and this administration act on that legislative initiative.

I come away with three themes from the federal standpoint that we need to be concerned about. Several were mentioned by you, others by the Governor.

One being stability of the funding. Radical changes in the federal funding streams for the delivery of the services are damaging.

Second, the ability to better coordinate the use of funds from a multitude of agencies that are primarily funded by the federal government.

Finally, we also need the flexibility to take the dollars that are already out there and use those as best applied at the local level.

I have two points I would like to follow up on. One is in response to the study, Dr. Behar, that you have performed. I was very interested in the cost comparisons of the demonstration model with what would have been the cost of the traditional CHAMPUS system. It seems like a rather substantial savings.

As a member of the Armed Services Committee, I am somewhat appalled at the fact we spend so much more money and require the traditional approach as opposed to what could be a substantial savings to the taxpayers if a community- based service system was utilized.

This also applies in general to insurance. So my first point, also mentioned by Ms. Huff and Dr. Cornelius, is the failure of the private insurance industry to respond to the needs and the direction that we should be going.

Why is that, in your opinion? As evidence by your own study, the savings could be and would be rather substantial. Why isn't that happening, and what can we be doing to further encourage a community-based system?

The second point, and I would like to start with Dr. Cornelius, is if you would comment based on your experience, is the need to provide more flexibility in terms of the current federal dollars. I invite the other members of the panel to response, as well.

Dr. Behar, I ask you to comment first on the basis of your study and the results that you have found. Why aren't we moving more in that direction as a society?

Dr. **Behar**. Well, I think philosophically among mental health professionals anyway and other concerned people, we are beginning to, and it is very encouraging.

If you look at the basis for medical insurance, you recognize that the insurance companies have always felt more comfortable paying for hospital services because the belief is that if somebody is in a hospital, they are really sick. They are beginning to change that belief. There are all kinds of ambulatory care programs and services outside of mental health.

They are concerned about things like quality assurance. They are concerned about things like "do people really need mental health services which are sort of expandable and contractible?" You do not go out and break your arm to get a service, but some people may believe that somebody goes for mental health service when something else will suffice.

I think convincing people through the kinds of studies that we are doing at Fort Bragg, the kinds of things that are going on in California, are going to be very important to document that these are children and families that have substantial needs that can be addressed and that they can make changes.

Because I think the other fear of third parties is that they are going to get into it for the long haul, which, of course, is what they really need to do, but they need to recognize that it is not going to be $641 a day now and forever more; that there are less expensive ways to do that.

So I think that that is one of the concerns. It has always been fascinating to me that there is no research literature that documents the effectiveness of hospital care versus other kinds of care. So it is in the best interest of the children and families that we care about to push other alternatives forward.

And I will repeat in closing what I said to Congressman Miller, and that is without the services in place, whether it is through state funding or federal demonstration funding, it is real difficult to get somebody to agree to pay and rely on reimbursement for services that don't exist.

Mr. **Weldon**. So you think it is in the process of evolving. What would help it along—perhaps a demonstration grant or seed funding? For example, funds provided by the Robert Wood Johnson Foundation and perhaps the federal government. Would that be of assistance in moving us in the right direction?

Dr. **Behar**. Yes, and of course, that is what the Department of the Army has done.

And one last point, and that is that the insurance companies have not teased out the fact that—many of them—that most of their expenditures for mental health are going for children and adolescents. Once you start looking at where the costs, where the dollars are really being spent, you begin to realize that this becomes a tremendous problem that has to be addressed.

Mr. **Weldon**. Was your study funded by the Army?

Dr. **Behar**. Yes, it is an ongoing demonstration project, and right now the budget, including the demonstration and evaluation costs, plus the clinical services costs, are a little over $12 million a year for this one catchment area, and we are in the first year of this project.

Mr. **Weldon**. Thank you very much.

Rather than take away time from anyone who would like to comment on that point—I would be happy to, but I would like Dr. Cornelius to talk about the need for perhaps more flexibility in block grant funds coming from the federal government and your own experience.

Dr. **Cornelius**. In my experience, there are more impediments to cross systems and family-based approaches at the state level than there are at the federal level. The waiver procedures in the medical assistance programs that allow us to have EPSDT funds extended to mental health prevention and family-based services are excellent. I mean that is a federal waiver, and the barriers are not exclusively, but primarily at the state level.

Going back to your question to Dr. Behar, in talking with some of the big insurance providers in the Philadelphia area, Signa and the like, it may be even more troublesome that they cannot tell me how much money they spend on mental health services for children. It may be such a relatively small percentage of their budget that the data is terrible, and they have got so many other fires in the insurance system that this is not one that they are willing or interested in taking on right now.

Mr. **Weldon**. Thank you.

Chairwoman **Schroeder**. Well, I, too, want to thank this very distinguished panel. You gave us a lot of things to think about. I guess the things that come to my mind are that I was pleased to hear about the Fort Bragg program, obviously, being on the Armed Services, too, and as Congressman Weldon pointed out, how happy we are that such efforts are beginning to happen because institutionalization seemed to be the main thing when we looked at CHAMPUS when it was going off the ceiling.

I am surprised that we still have such a small percentage being served even with that effort. While the population served is larger than that institutionalized, there remains still a real stigma, towards seeking services.

I thought that the point that, Barbara, you made was very moving, that we do have government policies where families when they are up against the wall economically or for whatever, they are forced to walk in and say, "I cannot take care of this child." That, to me, is one of the worst things, and we certainly have to be looking at that.

When you look at the models in health care, one of the things that always works best, which goes to what Dixie was saying, was the visiting nurses who used to go in and listen to people and say, "What is it you need?"

I think that the mental health part is very much that way, too, and I also hope we do not come down with just saying it is only divorces should be stopped. My guess is that some partners are abusive to the children and the children come out better for having the divorce.

So I do not think there is any real simple, preventative solution that if we stop the divorce, and I know you do not mean that, or if we mandated all grandparents and everybody had to live in the same city—good luck ever doing that in this culture—or whatever, we would really be able to solve the problem because we are not.

I think, as I listened to everyone, the first thing I thought is we ought to canonize the Robert Wood Johnson Foundation for getting out there and telling us, which is just common sense, and then how we do everything we can to de-stigmatize mental health so that we do not start saying that, gosh, if you have a mental health problem, you must be dysfunctional. You must have caused it. There is enough guilt in this society without adding all of that to it.

And then somehow figuring out how we can get services in a meaningful way. I often think, too, we have not used television and those kinds of resources enough. Someone was telling me that the majority of the mail that comes in on programs like "Family Ties" is people say they watch it to learn how to become a family, and you kind of think, "What? They watch a sitcom to figure out how to be a family?"

But we have not got very many models around for how you handle that, and the how-to-do sometimes seems to be so much more critical if you had some kind of support in that.

So I guess we all need to struggle with it. Barbara, the one question that I had that I wanted to follow through with a little bit was I know in the area of child abuse, the support of parent groups is really helpful in breaking that cycle. Now, that is a different kind of thing than what you are talking about here, but my guess is I assume what your group is trying to do is to take parents who do have mental health problems in the family and try and help them find services and that type of thing, the same kind of support.

Ms. **Huff**. Yes. I think support comes in a lot of different forms, and I think one thing that we noticed immediately is that it helped us to be able to talk about this without showing the stigma from our family and our extended family and friends, but then I think that—so that is one thing that an organization on a local and state level can do, and then when I think you push it to a national level or you start at a national level and push it down, that becomes much more the voice for children and the voice for families.

So it is definitely more the advocacy role as it moves up, but we find a lot of support for each other at board meetings, you know, that sort of thing, too. Many of us are involved in our state level in activities, and we notice out in the field in rural areas of Kansas how supportive it is for families to be able to get together on the phone or in each other's homes and that sort of thing to just talk.

So, you know, what you are talking about and Parents Anonymous, that they support each other and that they call each other to talk and that sort of thing, or Al-Anon or AA, any of those kinds of groups. I mean the support is definitely there for people, and I am not going to tell you that that kind of support is not meaningful to us because it is. Different, but it is also needed.

Chairwoman **Schroeder**. Different, but you are going to do something very important because we are hearing from everyone that some of the bureaucratic barriers are more at the state level than at the federal level. So you can help fight it at the state level.

Ms. **Huff**. That is right.

Chairwoman **Schroeder**. And there is nothing that state legislators hate more than an aggressive group of local constituents, right?

Ms. **Huff**. I know. I am a familiar face to our state legislators.

Chairwoman **Schroeder**. I will bet you are, too, Dixie, right?

Ms. **Jordan**. Well, I think you need to be, and I think what you were coming to earlier, the need for support groups, is a critical need because there are so few places to get help. Many of the parents in meeting groups in Minnesota will say such things as, "Well, you know, Johnny grabbed the steering wheel and tried to pull us off the road, and we went down an incline," and other parents can sit and laugh, and then they can say, "This is what you can do about it," because you do not get that information from systems.

I think, yes, you need to be a strong voice at the legislature. Something I think that is interesting about Minnesota. We have always had a great deal of pride in our social programs, and yet Minnesota has consistently ranked quite low in their delivery of mental health services, which is to say that we were one of the last three states to receive a grant from CASSP, one of the last three in the nation, and we received it only because PACER Center, which is a parent group, decided to write it for the state, and in collaboration with the state.

One of the components of that grant was that the Commissioners of the Departments of Health and Education and Social Welfare and Corrections would sit down together at the same table for the first time in the state's history. Now, I think that is an abomination.

Chairwoman **Schroeder**. It is an amazing fact isn't it?

Ms. **Jordan**. It is terribly sad.

Chairwoman **Schroeder**. That really says something.

Dr. Rekers, I know one of the things the University of South Carolina has done with their public television is television programming to child care providers because they are isolated and need to be able to have that kind of dialogue.

Maybe somehow we will get more educational television into this type of thing, too. It reaches out and people can do it in this very stressed-out society where everybody gets tired of going to meetings. You can watch those kinds of things.

So maybe we need to look at more ways to break through and use some of the technology we have there, too.

Ms. **Huff**. You know, I think that is an important thought. We are beginning to use some of the two-way interactive things in real Western Kansas to be able to kind of hook parents up to one another through that so that we can go out there and sit at one place in rural Western Kansas and talk to families in a variety of communities two and three hours away.

I think you are right. We have not begun to tap into the technology that really support some of those kinds of efforts.

Chairwoman **Schroeder**. I think we need to do it so much more because you keep hearing about the parenting deficit, and we all do feel that, and to be a good parent, you are to go to more meetings, which means that you are not home as much to be the good parent. You start driving yourself crazy. I think we need to find more ways to use some of those things that have been out there and we just have not been creative enough about getting the dialogue going. So hopefully we can do that.

I have kept you all much too long.

Mr. **Wolf**. If I could.

Chairwoman **Schroeder**. Certainly.

Mr. **Wolf**. I would like to just thank the panel and make two comments, and I am sorry Mr. Miller is not here.

I think a lot of the problems would probably happen even if everyone lived in a "Leave it to Beaver world." So nobody is suggesting that you really would need anything because even in families where there is actually a perfect situation, there are still some problems.

The concern that I have, and we do not have to get into this, is there does seem to be a growth industry here, and it is troubling. There are more child abuse, spouse abuse, teenage suicide, teenage pregnancy cases today percentage-wise than there were in the past.

That was the one point I wanted to make. The fact remains that even the most ideal families have problems. The problems are increasing at the very same time that we are putting supposedly more and more resources in.

Secondly, and I was glad Barbara Huff mentioned this, I think there was not very much emphasis here among the panel, but I think there really have to be more outside groups, PTA, Alcohol Anonymous, Al-Anon, etc.

In my church, we have a lot of those groups. There is a group in my district. The Women's Center has a lot of groups that could work. People who can come together and can talk about the problems so that they can know that there is somebody out there who looks pretty normal, but has had that same problem, and the group can deal with it.

And every group that comes to this town generally wants more money and more federal money, and that is why I was pleased that Governor Wilder did not come in asking basically for more money. I think it makes sense to look to outside community groups that are not necessarily governmental.

I just wanted to ask Dr. Behar one last question. You made a comment in your testimony that the military is doing a very good job. I tend to agree the Army is doing a good job. I think the Air Force is doing a good job. My sense tells me the Navy is not doing that good of a job. Do you have any sense of that or is the Navy up to speed with the Army?

General Wickham, who is Chief of the Army, instituted a lot of positive programs. The Air Force did, too. I have not sensed that on the part of the Navy. The Navy is a particularly difficult occupation because the very nature of the job requires you to be out to sea. If you are on a nuclear submarine, you are out to sea, for a long time. It is very difficult for some naval families when the husband comes back in, he is still out to sea because every third day they require them to go down, and it does not seem that the Navy is as far ahead as the Army and Air Force, when it comes to families.

I wanted your viewpoints, or is it just that the role of the Navy is so difficult? Airplanes come back to the SAC base, but that is not the case in the Navy. Do you have any thoughts about the Navy vis-a-vis the Army and the Air Force?

Dr. **Behar**. I have no experience to comment on that. I will tell you that some of the medical personnel at Camp LeJeune are very interested in doing a similar program, but your question aroused an opportunity to make a brief comment, and that is that all of the military posts, bases in this country, have the kinds of things available that we have all been talking about. They have for the most part real communities. They have support groups. They have education groups. They have churches and synagogues, and there is a culture in the military that supports all of this.

These are at least outwardly functional, if we have to use that word for the moment, functional families, but still these families have very serious mental health problems, and I think that everything that has been said about what is needed in society to support families is absolutely valid, but you have to also remember that families who have children who are developing problems tend to be very isolated until somebody reaches out to them, and when they reach the point that they need services.

The other thing about military families was CHAMPUS reimbursement of mental health services is supposed to be available. So you would think that that population would be freer of some of the kinds of problems we are talking about. They are not. They are not any better off, and yet they have a lot of the strengths that we would like other families to have.

Mr. **Wolf**. Well, I will send you a copy of an article that was in last Friday's "Washington Post" in the Style Section about enlisted families in the Navy. It was a tragic piece. I will send it to you and ask you for your comments, and then we will write the Secretary of the Navy asking if they have looked at some of the things that you have done to make sure that they are applying it across the board.

Again, I thank all of you for taking the time.

Chairwoman **Schroeder**. Well, I thank all of you, too, and I think that the idea that the Ozzie and Harriet syndrome is the only answer, we know what happened to Ozzie and Harriet. I think they had problems, too. So I really think it is important to point out that I thought your comments were very, very good.

There you have a community. You have a Chaplain corps that has supported you. You have done everything, and you have still got lots and lots of problems. So we have to say that many more times.

I think that is good enough to end up. Let me point out that the record will be open for two more weeks. We appreciate all of the witnesses for being here this morning. We only wish we had more time. You always feel like you are watching flowers on horseback or something as you go through this, as the Chinese say, but unfortunately that is the mechanism.

Thank you very, very much, and with that the hearing is adjourned.

[Whereupon, at 12:52 p.m., the select committee was adjourned, subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

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May 8, 1991

Congresswoman Patricia Schroeder, Chairwoman
U.S. House of Representatives
Select Committee on Children, Youth
and Families
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Representative Schroeder:

Attention: Joan Godley

RE: Submission of statement for the record to Hearings on; "Close to Home, Community Based Mental Health Services for Children".

On behalf of the State Mental Health Representatives for Children and Youth (SMHRCY), a division of the National Association of State Mental Health Program Directors (NASMHPD) I am hereby submitting the attached NASMHPD Position Statement on...The Federal Role in Children's Mental Health Services as a contribution, for the record, to testimony being collected on your recent hearings; "Close to Home, Community Based Mental Health Services for Children".

If you have any questions, need further information, or if I can be of assistance to you in any way, please feel free to contact me at (703) 739-9333.

Sincerely,

Roy E. Praschil
Assistant Executive Director
for Divisional Operations

cc: SMHRCY Executive Committee
Lenore Behar, Ph.D.
Harry C. Schnibbe
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N A S M H P D
INFO

MENTAL HEALTH
MENTAL RETARDATION
ALCOHOLISM
DRUG ABUSE

December 12, 1990

NASMHPD Position Statement on......

THE FEDERAL ROLE IN CHILDREN'S MENTAL HEALTH SERVICES

- Adopted by State Mental Health Directors at their meeting on December 7, 1990

Harry C. Schnibbe
Executive Director

Roy E. Praschil
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NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
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PREPARED STATEMENT OF ROY E. PRASCHIL, ASSISTANT EXECUTIVE DIRECTOR FOR DIVISIONAL OPERATIONS, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, ALEXANDRIA, VA

THE FEDERAL ROLE IN CHILDREN'S MENTAL HEALTH SERVICES

(as approved by the NASMHPD Board and membership 12/7/90)

Preamble

Children and their families, regardless of their composition or structure are this country's most valuable and perhaps most endangered resource. Families are responsible for the nurturance, safety, education, socialization and general development of their children. As this country enters the last decade of the twentieth century, the challenges facing families are unprecedented. Families must deal with illiteracy, drugs, persistent pockets of educational, social and economical poverty, eroding family structures and social, health and behavioral patterns that are often destructive.

It is both a legitimate and necessary role of government at all levels to provide, or cause to be provided comprehensive service and educational systems which support and help preserve families and ensure that systems do not inadvertently add to the challenges enumerated above.

This role for government must be legitimatized with a strong national policy that begins with a well articulated role for the federal government. This policy should drive the activities of all federal agencies and require agency coordination to support and ensure needed services for children and the preservation and improvement of families. Complementary and corresponding roles should be spelled out within each state in response to and as a part of this dejour national policy.

The goals of these efforts will be the provision of a coordinated community based system of care for children and their families which enables them to function at their highest possible level. The state mental health authorities are committed to actively contributing to this effort.

Background

Since 1984 Child and Adolescent Service System Program (CASSP) has been the mechanism for identifying and addressing critical issues facing families with children who have serious emotional disturbances. CASSP has created a movement and a momentum for change at all levels. It can and should serve as the vehicle for the development and articulation of national policy. The following points illustrate that fact:

- the development of new technology for intersystem collaboration and services
- stronger interagency collaboration at state and local levels
- enhanced leadership within states in the area of children's mental health
- an increase in the availability of community-based services

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- strong collaborative partnerships between the Federal government, states and national centers providing research, training, and technical assistance
- increased recognition of mental health needs of children through systematic state-based needs assessments
- increased financial support from private foundations for efforts to help develop and evaluate community-based systems of care
- development of a model of community-based system of care that serves as a framework for state mental health plans
- creation of opportunities for services research by expansion of innovative service components and systems of care
- initiation of research projects within states representing collaborative efforts between the public and academic sector
- widespread dissemination of research findings to mental health administrators and planners
- affirmation of the role of families as partners in:
    - system development
    - service design
    - treatment planning
    - care of children with emotional disorders
- development of a strong family-based advocacy movement for children with emotional disorders
- greater emphasis on the need to develop intervention techniques and service systems that are responsive to cultural differences
- an increase in state, local, and private funds for community-based services.
- the creation and restructuring of financial policies and strategies.

The activities of CASSP have not only produced a significant short-return on the CASSP investment but has the potential for producing even larger, more widespread, and long-term benefits through the continued combination of research, dissemination, innovation, constituency-building and system-change activities.

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Recommendations

Given the above mentioned accomplishments of CASSP and to continue the unfinished business of improving the children's mental health system, state mental health authorities support the following:

1. Strong federal leadership for children's mental health to support states and communities in the development of comprehensive, community-based service systems.

2. Federal resources and leadership to support the development in local communities of community-based services for youth who are seriously emotionally disturbed.

3. A leadership role for ADAMHA/NIMH in collaborating with other appropriate federal agencies to coordinate efforts to address the providing a role model for states and communities.

4. Strengthened technical assistance provided by ADAMHA/NIMH to assist states and communities in their system building efforts and to ensure continued knowledge development and dissemination regarding services for this population. Technical assistance should include:

    - the capacity and resources to enable all states (including those that no longer receive CASSP grants) to participate in relevant learning conferences and other information sharing and technical assistance activities,

    - expanded technical assistance on financing services for children with serious emotional disturbances and their families,

    - expanded technical assistance to develop a balanced system of care at the local level and which includes addressing the practice of inappropriate hospitalization.

    - expanded technical assistance for writing research/evaluation grant proposals.

5. Continued leadership and resources at ADAMHA/NIMH to support the development of statewide parent organizations and networks, which promote their participation in state and national policymaking activities.

6. Continued resources to ensure that all states are funded for a five-year period to continue their CASSP system development improvement efforts.

7. Resources to support expanded research in services and systems of care for children who are seriously emotionally disturbed and their families, with input from families, service providers and advocates, and in partnership with states.

8. Development and strengthening of public academic liaison regarding research and training to ensure adequate numbers of appropriately trained personnel for community-based service systems for the target population.

9. Promotion and funding of multi-disciplinary and cross-system training, through:

   - State/university collaboration in institutions of higher learning to meet the emerging competencies required by the child mental health workforce. Training must include outreach recruitment of minority students and other cross cultural issues.

   - Federal leadership in prevention, early identification and intervention for families with children at risk of developing emotional disorders.

   - Funding and technical assistance to states to implement the children's mental health data set as part of the Mental Health Statistics Improvement Program.

   - Collaboration with other federal programs in order to eliminate regulatory conflicts and barriers, and maximize creative financing to fund services which are family-centered and flexible.

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April 29, 1991

The Honorable Patricia Schroeder, Chair
Select Committee on Children, Youth and Families
U.S. House of Representatives
Washington, DC 20515

Dear Rep. Schroeder:

Thank you for the opportunity to submit comments for the record concerning the hearing topic, "Close to Home: Community-based Mental Health Services for Children." I am extremely pleased that you chose to focus one of your first hearings as chairperson of the Select Committee on Children, Youth and Families on the treatment of child and adolescent emotional disorders.

The continuum of care concept which allows youngsters to remain in the home or as close to home as possible has rapidly gained support, and this hearing provides an excellent opportunity to learn more about its efficiency and effectiveness. The American Academy of Child and Adolescent Psychiatry supports the use of a continuum of care for mental illnesses and has developed a fact sheet about it as part of our "Facts for Families" series on understanding child and adolescent mental illnesses. I am enclosing a copy for your information and for inclusion in the record.

Not every community can provide the range of treatment programs and services that constitute a full continuum of care, and often treatment plans are based on limited service resources. To enhance the continuum of care, the Academy's members, who are all child and adolescent psychiatrists, support legislation such as the recently introduced "Children's and Communities' Mental Health System Improvement Act." This bill builds on the National Institute of Mental Health (NIMH) Child and Adolescent Service System Program (CASSP) which helped states and communities develop strategies for a continuum of care.

Another important point, on the hearing's fact sheet, was that too few professionals specialize in children's needs. Specifically noted was the extreme shortage of child and adolescent psychiatrists. The reference to the shortage was especially timely since, earlier this year, the Subcommittee on Physician Manpower for the Council on Graduate Medical Education of the Health Resources and Services Administration requested that the Academy comment on a draft report assessing the manpower needs for several medical specialties, including child and adolescent psychiatry. The draft report contained a stunning recommendation.

Congress has requested periodic reports regarding the status of medical specialties, including a 1980 report that set 8,000 - 10,000 as the number of child and adolescent psychiatrists needed by 1990. The number available in 1980 was about 3,000. The 1990 report, using an updated model set a recommendation of **over 30,000**.

The Academy's current membership is about 4600, which constitutes a large majority of all physicians who have completed both general and child and adolescent psychiatric training. Without significant intervention and support, this medical specialty will not be able to recruit and train anywhere near the number recommended.

To encourage interest in pursuing the five to six year training program after medical school necessary to become a child and adolescent psychiatrist, a recommendation from the NIMH National Plan for Research on Child and Adolescent Mental Disorders should be considered. The plan called for child and adolescent mental disorders research to be declared a critical-shortage area, similar to AIDS research, and allow trainees to have all or part of their educational loans forgiven. The Academy has proposed a trial loan forgiveness plan which recommends that for every year in child and adolescent psychiatry training, one year of medical school debt be forgiven. And in the first two years out of training, for every year of full-time academic appointment or full-time work in a community or public service program, one year of debt be forgiven. We also recommend that the loan forgiveness formula be doubled for those who choose to work with the American Indian population, where the shortage of physicians and mental health professionals is critical.

There is a great amount of work to be done in securing services and providers of treatment and services for children and adolescents with mental illness. Thank you again for letting the Select Committee focus on this task.

The Academy members and staff are ready to support you and your staff at any time.

Sincerely,

John E. Schowalter, M.D.

John E. Schowalter, M.D.
President

enclosure: Facts for Families "Continuum of Care"

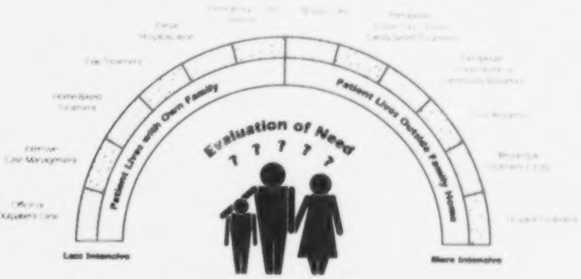
Facts for Families

from the American Academy of Child and Adolescent Psychiatry

No. 42 (3/91)

THE CONTINUUM OF CARE

Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. A complete range of programs and services is called the continuum of care. Not every community has every type of program on the continuum.


Office or Outpatient Care
Intensive Case Management
Home-Based Treatment
Day Treatment
Partial Hospitalization
Patient Lives with Own Family
Patient Lives Outside Family Home
Evaluation of Need
? ? ? ? ?
Less Intensive
More Intensive

The Continuum of Care

When parents are concerned about their child's behavior or emotions they should start with an evaluation by a qualified mental health professional such as a child and adolescent psychiatrist. At the conclusion of the evaluation, the professional will recommend a certain type of program from the continuum available in the community.

Each of the programs on the continuum offers several forms of treatment, such as individual psychotherapy, family therapy, group therapy and medications.

A brief description of the different programs on the continuum of care follows:

Office or outpatient clinic: Visits are usually under one hour. The number of visits per week depends on the youngster's needs.

Intensive case management: Specially trained individuals coordinate or provide psychiatric, financial, legal and medical services to help the child or adolescent live successfully at home and in the community.

Home-based treatment program: A team of specially trained staff go into a home and develop a treatment program to help the child and family.

Day treatment program: This intensive treatment program provides psychiatric treatment with special education. The child usually attends five days per week.

Partial hospitalization (day hospital): This provides all the treatment services of a psychiatric hospital, but the patients go home each evening.

Emergency\crisis services: 24-hour-per-day services for emergencies (for example, hospital emergency room, mobile crisis team).

Respite care: A patient stays briefly away from home with specially trained individuals.

Therapeutic foster care or foster family-based treatment: A surrogate family (professional parents) maintains and treats seriously emotionally disturbed children and adolescents in its own home.

Therapeutic group home or community residence: This therapeutic program usually includes 6 to 10 children or adolescents per home, and may be linked with a day treatment program or specialized educational program.

Crisis residence: This setting provides short-term (usually fewer than 15 days) crisis intervention and treatment. Patients receive 24-hour-per-day supervision.

Residential treatment facility: Seriously disturbed patients receive intensive and comprehensive psychiatric treatment in a campus-like setting on a longer-term basis.

Hospital treatment: Patients receive comprehensive psychiatric treatment in a hospital. Treatment programs should be specifically designed for either children or adolescents. Length of treatment may be acute (a few days to 30 days) or intermediate (30 to 120 days).

Parents should ask questions whenever a professional recommends psychiatric treatment for their child or adolescent. For instance, which types of treatment are provided, and by whom? Parents should also ask about the length of time, the cost, and the advantages and disadvantages of the recommended type of program. Parents should always feel free to obtain a second opinion about the best type of program for their child or adolescent.

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The AACAP has a membership of 6000 child and adolescent psychiatrists—physicians with at least 5 years of training beyond medical school in adult, child and adolescent psychiatry.

Washington Business Group on Health
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The Honorable Patricia Schroeder, Chairwoman
Select Committee on Children, Youth and Families
385 Ford House Office Building
Washington, DC 20515-8401

Dear Congresswoman Schroeder:

First, may we say how pleased we are that the Select Committee on Children, Youth, and Families has chosen to hold this hearing on the important subject of community-based mental health services for children. While a relatively small portion of the population, children with severe emotional disturbance and their families portray our most serious failings as a society. The shortcomings of our bureaucracies charged with crucial social welfare responsibilities are writ large for these children. And reform of these efforts will spearhead improvements which will improve society's response to the larger population of troubled children and youth and their families. We are grateful for this opportunity to address the Select Committee and hope these remarks will prove useful to your deliberations.

We want to address a very direct question which is central to the considerations of the Committee in this hearing:

> *How can the public sector and the private sector help families whose children suffer from serious mental disturbance?*

We will speak to this question from two experience bases, which may seem miles apart but are actually close together. First, as the President of the Washington Business Group on Health, Dr. England represents Fortune 500 companies seeking health reform which will support an increasingly talented and creative workforce. The disruption caused by mental illness and substance abuse costs these companies a lot of money. They recognize that healthy family life is an *essential* ingredient to a productive workforce. And second, we both are involved with the Mental Health Services Program for Youth (MHSPY), an initiative of the Robert Wood Johnson Foundation to assist state and community partnerships to create systems of care for the most seriously disturbed children and their families. As we work with five categorical agencies responsible for

Public Policy ◆ Institute on Aging, Work and Health ◆ Institute for Rehabilitation and Disability Management ◆ Mental Health Services Program for Youth
National Business Coalition Forum on Health ◆ National Resource Center on Worksite Health Promotion ◆ Prevention Leadership Forum ◆ Quality Resource Center

these children, it is clear that the comprehensive approach, possible only for the public-sector agencies, is the only effective approach to the problem. The public sector needs the collaborative support of the private purchasers of health care, but the private sector needs the comprehensive capacity of the public agencies.

The answer which we propose for this question is simple and straightforward:

> *By doing a few obvious things well!*

We mean specifically three things. First, the public and private sectors must respond directly to support families with disabled or troubled children. Second, they must streamline the administrative mechanisms through which services are made available to children and families in need. And, finally, they must rationalize the way they finance services. We will elaborate these three modest proposals for the consideration of the Select Committee.

1. Direct Support to Families of Children with Severe Emotional Disturbances: The System of Care

We need to organize integrated systems of care in every community, or, as the private sector says, in every "market." The public sector must effectively integrate health and human services entitlements and organize multi-agency collaborative efforts to serve children and their families. And the providers and payers of the private sector must organize health care delivery systems which complement, where appropriate, the larger public and community service entitlements. And in any given community we must create strong affiliations among categorical agencies, providers--both public and private--and genuine collaboration that is results-oriented.

We have some wonderful models to guide us in this endeavor. In the decade of the 1980s the groundwork has been laid for this kind of reform. The Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (NIMH) has, through a network of planning efforts in each state, laid out the blueprints for the system of care. Models have been demonstrated in such programs as the Willie M. Consent Decree in North Carolina and the Ventura County, Calif., model. And our eight sites of the MHSPY, a number of whom are represented in this hearing, are working to create systems of care based on these blueprints and models.

We need serious initiatives to **prevent** major disability or dysfunction by means of early intervention. And the system of care is the way to effectively intervene. "Prevention" has been a term out of favor in recent years, and we stress the importance of rigorous and focused prevention programming.

If you review the record of almost any "young adult chronic patient," you will find a history of sporadic and uncoordinated efforts to intervene on the part of private and

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public provider agencies and, all too often, the gradual or abrupt disintegration of the young person's family. As decent and well meaning as any one intervention might have been, the cumulative story is one of disaster. And if you look into the future of that young person, too often you can predict a lifetime of disability and public dependence.

We cannot afford **not** to adopt **prevention** as a major public priority. And prevention is the work of the *System of Care* intervening early and effectively to support families to care for children at risk of serious mental disability. Prevention cannot be thought of as "soft" services to the worried well which in recent years have been the target of budget cuts, but flexible and practical services aimed at a target population at risk of the most severe disability.

2. Streamline Administrative Mechanisms: Benefits, Payments, and Processes

We find that it is the *mechanisms* which stop us from doing the most obvious things: methods of payment, accounting practices, and administrative procedures which seem arbitrary, but actually shape how well and how quickly we can respond to a given child's and family's needs. Fee-for-service claims payment by public or private third-party payers encourages medical providers to act like pushcart vendors in an age of supermarkets; partitioning of funds to different categorical agencies discourages interagency collaboration; purchase-of-service methods designed to buy office supplies make the purchase of in-home care for a troubled child awkward and ineffective.

We have some suggestions for the revision of administrative practices by both the public and private sectors:

We need to end the payer-of-last-resort requirement for public benefits, and to require private benefit participation early on. In our Dane County, Wisc., site several health maintenance organizations are negotiating to purchase crisis intervention and case management services from the interagency system of care. By doing so they open the potential for developing a plan of care in which private benefits will be coordinated with the broad array of public benefits. **But**, to do this we may have to redefine the benefits so that the public services, which we are asking Medicaid to cover, interlock without "overlapping"--an artificial exercise at best. But if we can do it, we will avoid the typical scenario in which the private psychiatric benefit is spent out--a lifetime maximum of $50,000 usually can be exhausted in less than 45 inpatient days--and then the child, still with a lifetime of disability ahead of him, is discharged to home and the public-sector services.

We need benefit design that is based on a model of comprehensive family support. Let us describe briefly what the elements of a model of comprehensive family support might be. First, *Case Management*, one identified "clinical broker" to assist the family to make the multi-agency system work for them and their child, providing utilization management and concurrent review of all treatment resources. Second, sound and accurate *Clinical*

Assessment and long-term direction of the child's treatment . . . a medical/clinical home providing guidance throughout the important developmental years, especially in the case of children with serious disabilities. Third, some form of *Emergency Support* to families and their children, whether it be along the lines of the highly successful "Home Builders" model, emergency respite capacity, or short diagnostic inpatient programs with "back door" capacity to return children rapidly to home or normalized homelike settings as quickly as possible. Finally, flexible *Supportive Services* capacity which can keep a child in home or school settings through difficult adjustment periods.

Benefits for children with serious disabilities should be controlled through reference to a formally conceived plan of care rather than set of fixed service definitions. And this is why the ability to make benefits flexible under capitation or other provider risk-sharing models are so important.

Finally, we need to coordinate benefits and entitlements, both public and private, to eliminate barriers to ready access for services that families and children need. There is no good reason why we cannot have a uniform claim form for public and private benefits. If planning for a complex case were unified, it would save the expense of every fault of coordination which we now experience.

3. Rationalize Financing for Services

The ways in which we finance services to children with serious mental illness present a remarkable tangle of policy and practice. Public funds come through five categorical agencies which are not effectively coordinated even when organized in integrated human services umbrella agencies. Third-party payers, both private and public, have narrowly defined benefits which are sometimes an invitation to misspend rather than effectively treat. Families are at the mercy of an uncoordinated complex of agencies which they must organize if their children are to be served. And they suffer under this burden, as do their children. Again, we have a few suggestions.

First, we need the capacity to fund individually tailored packages of services creating a system of care around each disabled child and his/her family.

An example of financing policy and practice that achieve this can be found in the state of Vermont's Home and Community-Based Services Waiver (Medicaid 2176 waiver). Over the last seven years Vermont has developed a system whereby:

- when a child is determined "at risk" of psychiatric hospitalization, s/he is deemed eligible for Medicaid services;

- an elaborate plan of care is drawn up by an interdisciplinary team of clinicians with virtually no

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constraints and full flexibility as to individually tailored in-home and supportive services;

- a contract with a local provider (usually a community mental health center) is negotiated for the whole services package "at cost" (not at fee-for-service rates, which are usually set at 80 percent of cost);

- the provider is paid the global monthly rate for the whole package; and

- the plan of care is reviewed quarterly and reauthorized every six months.

Another example can be found in capitation funding to encourage well-organized treatment involving all responsible categorical agencies and even private third-party payers and providers.

In Ohio's Cuyahoga County (Central and East Cleveland) and Oregon's Multnomah County (Portland), our sites are experimenting with Medicaid's 1915(a) option whereby a "continuing care provider" takes responsibility to care for a defined target population within a defined geographical area (avoiding "statewideness") for a specially designed benefit (independent of the state Medicaid plan). They receive a capitated fee on a monthly basis for each child enrolled and have complete flexibility to respond to the needs of an individual child and family and to organize services accordingly.

Second, we need public financing policies which allow and encourage the coordination of funds across categorical barriers. Several of our sites are considering the use of Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program as the glue to coordinate multi-agency efforts. Oregon has implemented a multi-agency "preadmission screening" mechanism statewide as a way to fulfill the new EPSDT provisions called for in the Omnibus Budget Reconciliation Act of 1989. In our San Francisco, Calif., and Madison, Wisc., sites, we are investigating the use of the 1915(a) capitation arrangements as a vehicle for providing continuing care under EPSDT for seriously disabled children in such a way that existing expenditures from various categorical agencies can be pooled to make up the state/local match. Services could thus be increased through new federal funds without increasing state/local appropriations.

Third, we need to end cost-shifting practices. However praiseworthy they may have been in their historical origins, they are confusing and dysfunctional in modern health care financing practice. When a child with serious disability is referred, all five categorical agencies, and even the responsible third-party payers, should sit together from the very beginning to devise short-term intervention and long-term treatment strategy. All needed benefits should be coordinated and there should be nowhere to shift costs.

And finally, we need carefully designed risk pools which consolidate private contributions and public subsidies so that universal coverage can be achieved.

States, such as New Jersey, struggling to reform the way their "uncompensated care" funds work, are proposing major initiatives to manage care and subsidize risk pools in such a way as to approach community rating.

Proposals to create authorities to manage competition (such as that developed by Alain Enthoven of Stanford University) incorporate public subsidies to risk pools which enable the same effect of approximating community rating.

This is surely an issue relevant to overall health care reform. It is critical that the needs of these high-risk children are considered so that they will find a place in a larger risk pool.

Finally, we would like to conclude by pointing out four values which have emerged as we have begun to engage in implementing the systems of care planned by the MHSPY sites.

> *Individuation of Care*
>
> Through effective interagency collaboration, a comprehensive program of care must be developed that is tailored to the specific needs of the child and his or her circumstances.
>
> *Coordination of Care*
>
> To maximize the effectiveness and comprehensiveness of the intervention, the coordinated efforts and resources of all responsible parties, public categorical agencies, third-party payers, and community agencies must be effectively organized and directed to support the child and his or her family.
>
> *Financing of Care*
>
> Complex and often contradictory funding policies must be rationalized so that the available dollars follow the specific needs of the child rather than the other way around.
>
> *Normalization of Care*
>
> Intensive care for mentally ill children must be available within the same family, school, and community environments created for normal children. Acute inpatient confinements or residential care in institutional settings should be used only when appropriate.

The clarity of these values bespeaks a growing consensus among health and human services professionals and among families that we do have a clear agenda for reform. We have been encouraged by proposed legislation, sponsored by members of this Committee, which will provide funds to states to initiate the development of systems of care and to do a few of these "obvious" things we discuss here. Passage of this legislation and its full appropriation is of the highest importance to troubled children and their families. And we feel that Health and Human Services Secretary Louis W. Sullivan's new Administration for Children and Families should have direct responsibility to implement this important initiative.

The broader and critical issues of social welfare reform which affect disadvantaged children and their families are, of course, neither simple nor obvious. But we believe that the target population of children with serious emotional disturbance is the Rosetta Stone to decipher the puzzle of child and family policy issues. If we can respond to the needs of these most troubled children and their most beleaguered families, we will know how to organize our efforts and resources to help all other children and families.

Thank you for your attention. We hope these comments will prove useful to the Committee and look forward to its findings.

Sincerely,

Mary Jane England, MD

Mary Jane England, MD
President, Washington Business Group on Health
Director, Mental Health Services Program for Youth

Robert F. Cole, PhD
Deputy Director, Mental Health Services Program for Youth

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